

Progestagens and anti-progestagens for pain associated with endometriosis (Review)

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[Intervention Review]

Progestagens and anti-progestagens for pain associated with endometriosis

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ABSTRACT

Background

Endometriosis is a gynaecological condition that presents either with the problem of infertility or with painful symptoms. The clinical observation of an apparent resolution of symptoms during pregnancy gave rise to the concept of treating patients with a pseudo-pregnancy regime. Initially combinations of high dose oestrogens and progestagens were used but this was subsequently replaced by progestogens alone. More recently progestogens of both progestagens and anti-progestagens in the treatment of symptomatic endometriosis.

Objectives

To determine the effectiveness of both the progestagens and anti-progestagens in the treatment of painful symptoms ascribed to the diagnosis of endometriosis.

Search strategy

The search strategy of the Menstrual Disorders and Subfertility Group was utilised to identify all publications which described or might have described randomised trials of any progestagen or any anti-progestagen in the treatment of symptomatic endometriosis.

Selection criteria

Trials were included if they were randomised and considered the effectiveness of either a progestagen or an anti-progestagen in the treatment of painful symptoms associated with endometriosis.

Data collection and analysis

Seven studies were considered to be appropriate for inclusion in this review. Only three studies evaluating progestagens were included (comparison with placebo, danazol and oral contraceptive plus danazol). All other studies compared the anti-progestagen, gestrinone, with other medical therapies.

Main results

Progestagens appear to be an effective therapy for the painful symptoms associated with endometriosis. Gestrinone is as effective as other established medical therapies (danazol and GnRH analogues).

Authors' conclusions

The limited available data suggests that both continuous progestagens and anti-progestagens are effective therapies in the treatment of painful symptoms associated with endometriosis. Progestagens given in the luteal phase are not effective. These conclusions should be accepted cautiously due to a lack of data.

PLAIN LANGUAGE SUMMARY

Progestagens and anti-progestagens for pain associated with endometriosis

Progestagens and anti-progestagens can help reduce the pain from endometriosis. Endometriosis is a painful condition where tissue from the lining of the womb (uterus) is outside the uterus as well. It can cause pain in the abdomen generally, and during periods (menstruation) or sex. Endometriosis can also lead to infertility. Treatments include surgery, or drugs to try and shrink the tissue. Progestagens and anti-progestagens are some of the hormonal drugs used. The review of trials found some evidence that these drugs can help reduce the pain from endometriosis.

BACKGROUND

Endometriosis is a gynaecological condition that presents either with the problem of infertility (Haney 1993, Prentice 1996) or with painful symptoms (Barlow 1993). The painful symptoms may take the form of dysmenorrhoea (painful periods), dyspareunia (pain during or after sexual intercourse) or pelvic or lower abdominal pain. Less commonly patients also present with cyclical pain at other sites relating to endometriosis at extra pelvic sites (Lancaster 1995). Although the exact incidence of endometriosis is unknown endometriosis is a significant problem for the affected individual and the cost of the disease is high both in human and economic terms (Mathias 1996).

The precise pathogenesis (mode of development) of endometriosis remains unclear but it is evident that endometriosis arises by the dissemination of endometrium to ectopic sites (sites other than its normal location within the uterus and the subsequent establishment of deposits of ectopic endometrium (Kruitwagen 1993; McLaren 1996). The assumption is made that these deposits of ectopic endometrium are responsible for the symptoms of endometriosis. Conventional treatments, therefore, are directed at the removal of all ectopic tissue. Surgical treatments achieve this by destroying or removing the implant whilst medical therapies induce atrophy within the hormonally dependent ectopic endometrium so they shrink in size and number. Medical treatments, theoretically, have the ability to treat those implants not visible to the naked eye.

The clinical observation of an apparent resolution of symptoms during pregnancy gave rise to the concept of treating patients with a pseudo-pregnancy regime (Kistner 1959). Initially combinations of high dose oestrogens and progestagens were used but this was subsequently replaced by progestagens alone (Kistner 1958). More recently anti-progestagens have been developed and they have also been employed in the treatment of endometriosis (Thomas 1987a). Treatments employed by clinicians in the management of endometriosis may reflect personal preference or knowledge but equally may be influenced by available resources. Progestagens are readily available, relatively inexpensive drugs that may have a better side effect profile than other agents, such as danazol, and therefore may be useful in the management of endometriosis. This review evaluates the role of both progestagens and anti-progestagens in the treatment of symptomatic endometriosis.

OBJECTIVES

To determine the effectiveness of both the progestagens and anti-progestagens in the treatment of painful symptoms ascribed to the diagnosis of endometriosis. The following hypotheses were tested:

1. Treatment with either a progestagen or an anti-progestagen is more effective than placebo in relieving or reducing painful symptoms.

2. Treatment with either a progestagen or an anti-progestagen is more effective than no treatment in relieving or reducing painful symptoms.

3. Treatment with a progestagen is more effective than treatment with other medical therapies (danazol, gonadotrophin releasing hormone analogues, anti-progestagens) in relieving or reducing painful symptoms.

4. Treatment with an anti-progestagen is more effective than treatment with other medical therapies (excluding progestagens) in relieving or reducing painful symptoms.

5. Treatment with either a progestagen or anti-progestagen is more effective than conservative surgical treatment in relieving or reducing painful symptoms.

6. Treatment with continuous progestagen is no better than treatment with intermittent progestagen in relieving or reducing painful symptoms.

7. Treatment with varying doses of progestagen or anti-progestagen are equally effective in relieving or reducing painful symptoms.

8. Treatment with a progestagen is associated with a lower incidence of side effects and higher compliance than other medical therapies (see above).

9. Treatment with an anti-progestagen is associated with a lower incidence of side effects and higher compliance than other medical therapies (excluding progestagens).

METHODS

Criteria for considering studies for this review

Types of studies

All randomised controlled comparisons of the use of progestagens and anti-progestagens in the treatment of symptomatic endometriosis. Both trials with placebo arms and with no treatment arms were considered but the data was analysed separately.

Types of participants

This review considered studies that include women of reproductive years complaining of symptoms ascribed to the diagnosis of endometriosis. The diagnosis was made by laparoscopy. Studies in both the primary and secondary health care settings were considered.

The painful symptoms associated with endometriosis that were considered were: cyclical pain associated with menstruation (dysmenorrhoea) or not associated with menstruation; deep dyspareunia (pain during or following sexual intercourse); lower abdominal

or pelvic pain of a non cyclical nature; pain on defaecation and; any other painful symptom ascribed to endometriosis studied in any trial was also considered. All studies, whether the duration of symptoms was specified (3 or 6 months) or not, were included. Trials where participants had asymptomatic disease or infertility alone were not considered.

Types of interventions

Only those treatments where the aim was to achieve symptom relief through disease resolution were considered. Treatment with any progestagen or anti-progestagen versus GnRH analogue danazol, placebo or no treatment was considered irrespective of dosage, route of administration or duration of treatment (3 or 6 months). The surgical treatments of ablation and excision of endometriotic implants or those that purport to interrupt neural pathways (presacral neurectomy or LUNA) would have been considered but no trials were identified.

Studies where the only treatment was for symptomatic relief or the surgical procedure was not conservative were not considered. Also excluded from consideration were studies of alternative or complementary therapies which should be considered in a separate review.

Types of outcome measures

Both subjective (as reported by the participants) and objective (as measured independently) outcome measures were considered for each pain symptom where possible. Outcome measures were considered at the end of treatment and when possible at 3, 6, 9, 12 and 18 months later. Subjective symptomatic relief (of any or all symptoms) was considered using both quantitative measures such as visual analogue scales or qualitative measures such as cured, better, same or worse.

Objective evaluation of resolution of endometriotic implants was also assessed where possible. Although this is neither a direct or indirect measure of pain it is an independent assessment of disease resolution and it is important to be able to distinguish those women who continue to experience symptoms in the absence of visible disease. Two scores are used; the revised American Fertility Society (AFS) score and the implant score which excludes adhesions from the assessments as they are unlikely to respond to medical treatment. Distinction has not been made between those studies where relaparoscopy occurred during treatment and those that followed treatment, as the comparison, in each case, was made with a group managed in an identical way.

The occurrence of side effects was considered as a separate outcome measure. Side effects were considered whether they occurred during therapy or persisted after treatment. Compliance with therapy and withdrawal from intended treatment group was also considered.

Search methods for identification of studies

The search strategy of the Menstrual Disorders and Sub-fertility Group was utilised to identify all publications which described or

might have described randomised trials of any progestagen or any anti-progestagen in the treatment of symptomatic endometriosis. For a full outline of the Review Group search strategy see Review Group details. In addition the following terms were included in the electronic search strategy: progestagen, antiprogestagen, norethisterone, medroxyprogesterone acetate, dydrogesterone, norethynodrel, lynestrenol, gestrinone. These terms were also used to search the Cochrane Controlled Trials Register.

Data collection and analysis

The assessment of the quality of trials identified by the search strategy was undertaken by two of the reviewers. This enabled identification of trials of low quality. Where uncertainty existed regarding suitability for inclusion or discrepancy existed between the initial two reviewers a third reviewer made a further assessment. If required additional information was sought from the principal or corresponding investigator of the trial. The quality of trials for inclusion was assessed using a standard checklist developed by the review group. The quality of allocation concealment was graded as either A (adequate), B (unclear) or C (inadequate). For all trials included the following information was collected: the method of randomisation, allocation concealment, blinding, the possibility of performing an intention to treat analysis and the intended interventions and measured outcomes.

Data was extracted by the same two assessors. At least one of the assessors was an expert in the content matter. For data extraction, forms developed according to Cochrane guidelines were utilised. In some papers, data was presented in graphic form. Where this was the case, the authors have been approached for clarification, and if necessary, the data have been extracted from the graphs.

Statistical analyses were performed according to the statistical guidelines for reviewers in the Menstrual Disorders and Subfertility Review Group. Briefly, it was planned to use the Relative Risk as the measure of effect for dichotomous data. For continuous data, weighted mean differences were used whenever outcomes were measured in a standard way across studies. However, as many different methods exist for assessing pain, standardised mean differences were used when comparing multiple methods. Although different methods give different absolute values, they are conceptually measuring the same parameter. Different methods of measuring pain were considered together, and not subjected to separate sub-group analyses. Where there were sufficient data, a summary statistic for each outcome was calculated using both a fixed effect, and a random effects model. Heterogeneity in the data was noted and cautiously explored using the previously identified characteristics of the studies, particularly assessments of quality. Sensitivity analyses were undertaken to examine the viability of the results in relation to a number of factors including study quality and the source of the data (published or unpublished). See Review Group module details for more information.

RESULTS

Description of studies

See: [Characteristics of included studies](#); [Characteristics of excluded studies](#); [Characteristics of studies awaiting assessment](#).

Only two randomised studies were identified that considered the role of progestagens alone in the treatment of symptomatic endometriosis [[Overton 1994](#); [Vercellini 1996](#)]. Other studies were identified but excluded because some subjects received operative treatment (see table of excluded studies for details) and a third study was included despite the fact that some participants had received operative therapy at the time of diagnostic laparoscopy ([Telimaa 1987b](#)).

Overton and her colleagues ([Overton 1994](#)) considered three groups of women with symptomatic endometriosis who wished to achieve a pregnancy. Patients received either placebo or one of two doses (40 or 60 mg) of dydrogesterone in the luteal phase of the cycle. The endpoints of this study relevant to this review were reduction in pain scores (derived from diary cards) and reduction in AFS (American Fertility Society) scores (second look laparoscopy performed within three months of the end of treatment). Of the 62 participants only 39 completed the study and had a second look laparoscopy.

In another RCT considering a progestagen Vercellini and colleagues ([Vercellini 1996](#)) compared 150mg of depot medroxy progesterone acetate with a combination of a 20mcg oral contraceptive pill and 50mg of danazol. Both the pill and the danazol were taken for 3 weeks out of 4. The primary endpoint was to determine patient satisfaction after 1 year of therapy.

Finally, [Telimaa 1987b](#) compared three groups of participants with mild to moderate endometriosis who had no previous surgical or medical treatment. They were randomised to treatment with danazol (200mg tds, 18 participants), medroxy-progesterone acetate (100mg daily, 16 patients) or placebo 16 patients. Participants received identical packets of tablets such that each group took the same number of tablets daily with those in the active danazol group receiving placebo medroxyprogesterone acetate and vice versa. Unfortunately 27% of participants were subjected to a surgical co-intervention at time of diagnostic laparoscopy but these participants were evenly divided between the groups.

No other studies, suitable for inclusion, were identified comparing progestagens with any other medical or surgical therapy.

No placebo controlled or no therapy controlled studies of the anti-progestagen, gestrinone, were identified. In addition there were no studies comparing gestrinone with any progestagen.

Two studies were identified comparing gestrinone with danazol ([Fedele 1989](#); [Bromham 1995](#)). Fedele reported on 39 patients with laparoscopically diagnosed endometriosis. Treatment was randomised to either 2.5mg gestrinone twice weekly (or thrice weekly) or danazol 600-800mg daily. Danazol was increased to 800mg daily and gestrinone to thrice weekly if amenorrhoea was not achieved at the lower dose. Objective efficacy data in this study

is limited to 16 patients who had repeat laparoscopy. The patients in this study were primarily attending for infertility but pain was also considered as an endpoint.

[Bromham 1995](#) was a larger multicentre study (269 patients) whose primary complaint was pain. Repeat laparoscopy was carried out after the end of treatment. Pain was graded using the scale none, mild, moderate or severe.

One multicentre study was identified that compared gestrinone with the GnRH analogue, leuporelin ([GISG 1996](#)). This compared 2.5mg gestrinone orally twice weekly with intra-muscular leuporelin depot (3.75mg) monthly. Both groups received a placebo. A total of 55 patients were studied.

One small study, 6 patients in each arm, has compared two doses of gestrinone 1.25 v 2.5mg orally twice weekly ([Hornstein 1990](#))

Risk of bias in included studies

Four studies were of sufficient quality to be graded as A in the methodological quality assessment ([Hornstein 1990](#); [Overton 1994](#); [Bromham 1995](#); [GISG 1996](#)). [Vercellini 1996](#) was graded B because the method of randomisation was not specified and the patients or observers were not blinded after randomisation. Another study ([Telimaa 1987b](#)) was also graded B and again the method of randomisation was not specified. This study however suffers from a surgical co-intervention in 27% of participants. The surgical co-interventions were evenly distributed between the groups. The seventh included study ([Fedele 1989](#)) was graded C because it was an open study, with no intention to treat analysis and the method of randomisation was not specified.

In two studies large losses to followup were reported. In [Bromham 1995](#) 124 of the 269 patients did not complete the trial; 5 conceived before treatment, 69 withdrew during treatment and 50 were lost to follow up. Similarly in [Overton 1994](#) 5 patients were excluded post randomisation (4 conceived) and 23 were lost to follow up out of a total of 62 patients. Losses were equally distributed between the groups.

Effects of interventions

There was one controlled trial of continuous progestagen therapy against no treatment or placebo ([Telimaa 1987b](#)). This group compared the progestagen, dydrogesterone with either placebo or danazol. This trial include only a small number of patients (16, 17 and 18 in each of the three groups). Subjectively dydrogesterone was more effective for reducing both pelvic pain and the sum of all symptom scores both at the end of treatment (WMD -1.3 95%CI -1.633 - -0.967) and at the end of six months follow up (WMD -5.2 95%CI -6.797 - -3.603). Interestingly whilst a subjective response was seen there was no objective improvement in AFS scores reflecting the fact that timing of second look laparoscopy is important in the identification of endometriosis. In this study repeat laparoscopy was conducted 6 months after the completion of treatment and this does question the assumption

that the implants themselves are the cause of the pain. In comparison with danazol no difference was seen between the two active treatment groups at the end of treatment but after six months follow up the dydrogesterone group had significantly lower total pain scores (WMD -3.4 95% CI -4.829 - -1.971). In terms of side effects active treatment with dydrogesterone was associated with a higher incidence of both acne and fluid retention when compared with placebo whilst comparison with danazol demonstrated no significant differences.

There was one trial comparing cyclical (luteal phase) therapy of two different doses of dydrogesterone versus placebo (Overton 1994). In this trial there was no significant difference in the objective efficacy (change in AFS scores) of dydrogesterone at either dose versus placebo. For 40mg dydrogesterone the odds ration for improvement of pain against placebo were 0.70 (95% CI 0.13 - 3.68) and for 60mg the odds ratio was 2.60 (95% CI 0.48 - 14.06). Care should be taken in interpreting this data as the wide confidence intervals suggest that inclusion of additional, new data might significantly change the conclusion. Subjectively there appeared to be a trend towards an improvement in symptoms at the higher dose of dydrogesterone at end of treatment but this did not reach statistical significance and any benefit was lost by end of follow up. Three patients withdrew from the study due to severe headaches (2 in 40mg group and 1 in 60mg group). Two patients receiving 60 mg withdrew because of menstrual cycle irregularity. Vercellini 1996 compared depot medroxy progesterone acetate with a combination of a low dose oral contraceptive pill and danazol. The original data is presented in tabular form. The progestagen appeared to be more effective only in the reduction of dysmenorrhoea at 12 months and all values in both groups were significantly reduced from baseline. Patients on progestagenic therapy experienced a higher incidence of the side effects bloating (OR 4.04 95%CI 1.68-9.7) and spotting (OR 16.33 95%CI 6.8-39.19) but benefited from a greater incidence of amenorrhoea (OR 8.98 95%CI 2.10 - 38.33).

There were no randomised controlled trials of gestrinone against no treatment or placebo.

Two studies compared the efficacy of the antiprogestagen gestrinone with danazol (Fedele 1989; Bromham 1995). There appears to be no difference in either the objective or subjective efficacy between these two drugs. Of particular note is that the confidence intervals relating to the relative risk are tight (for none or mild pelvic pain experienced by those treated the OR was 1.2 95% CI 0.58 to 2.48), suggesting that there are no underlying differences between the two treatments rather than there was no difference due to lack of power. However when considering objective measurement of effectiveness (the AFS score) wide confidence intervals are seen (WMD 1.4 95%CI -6.758 - 9.558). Potentially these relatively large changes in AFS score would move patients from one category of severity of endometriosis to another and again demonstrates a discrepancy between the subjective assessment of pain and the objective assessment using the AFS score. Observed

differences were restricted to differences in the side effect profile with the androgenic side effects of greasy skin (OR 2.68 95%CI 1.67 - 4.31) and hirsutism (OR 2.63 95%CI 1.62 - 4.28) being more common in the gestrinone group. Decreased breast size (OR 0.62 95%CI 0.39 - 0.98), muscle cramps (OR 0.49 95%CI 0.31 - 0.78) and hunger (OR 0.59 95%CI 0.36 - 0.97) were more common in the danazol group. It was proposed undertake both sensitivity and heterogeneity analysis. In the majority of circumstances this was not required as only one trial existed. However in the comparison of side effects between gestrinone and danazol significant heterogeneity exists. Clinically the two major differences between the study populations was country, Italy vs the United Kingdom and secondly that the population in Fedele 1989 were diagnosed during infertility laparoscopy. It is interesting to note that in Bromham 1995 the incidence of side effects in the control group, treated with danazol, is consistently higher than that observed in the Fedele study (Fedele 1989).

One study (GISG 1996) has compared gestrinone with the GnRH analogue, leuporelin IM. There appeared to be a small benefit at end of treatment, with respect to dysmenorrhoea, when using the GnRH analogue (WMD 0.82 95%CI 0.146 - 1.494). However, by the end of follow up the advantage was with gestrinone (WMD -3.00 95%CI -4.787 - -1.213). In both treatment arms, however, the values obtained were significantly less than those at baseline were. The situation for pain during intercourse and non menstrual pain is similar with the greater reduction in symptoms being recorded on a visual analogue scale than on the verbal rating score (Pain during intercourse visual analogue score at end of follow up WMD -2.34 (95%CI -3.662 - -1.018 and verbal rating score WMD -0.54 95% CI -0.939 - -0.141). Again at six months post treatment patients in both treatment groups had a significant reduction in pain scores from those observed at baseline.

There was also found to be no significant difference in the side effect profile of the two treatments, apart from hot flushes being significantly more common in the GnRHa group (OR 0.22 95% CI 0.08 -0.64). Four of the gestrinone group and 2 of the GnRHa group dropped out during the treatment period.

Change in rAFS score was not studied in this trial.

Hornstein 1990 compared two doses of gestrinone (1.25mg and 2.5mg twice weekly). No difference in efficacy was noted but patients receiving the lower dose were less likely to experience side effects. This study considered only 12 subjects.

DISCUSSION

There is a paucity of data, derived from randomised controlled trials, relating to the use of either progestagens or anti-progestagens in the treatment of painful symptoms associated with endometriosis. None of the studies included contain large enough numbers of patients to enable the drawing of firm conclusions.

Nevertheless it would appear that neither continuous progestagens or anti-progestagens are no more or less effective than other medical treatments of endometriosis. As these alternative treatments have been shown to be effective e.g. danazol we can conclude by extrapolation that continuous progestagens and anti-progestagens are likely to be effective.

There is a particular lack of data relating to the use of progestagens with only one randomised controlled trial considering continuous progestagens (Telimaa 1987b) and one considering only luteal phase therapy (Overton 1994)]. This latter study compared dydrogesterone with a placebo but from it we cannot definitely conclude that dydrogesterone given in the luteal phase is an effective treatment. The former study contains only small numbers is confounded by the presence of a surgical co-intervention but does appear to show a benefit in using medroxyprogesterone acetate over placebo. No comparisons of gestrinone with either placebo or no treatment have been made. However comparisons have been made with both danazol and GnRH analogues, both of proven efficacy, and as gestrinone appears to be no better or worse than either we can conclude it is an effective treatment.

Caution should be exercised in accepting these conclusions because of the paucity of data.

progestagen, gestrinone are effective therapies for the treatment of painful symptoms associated with endometriosis. This conclusion is based on the limited data available in the seven included studies and should be treated with caution particularly in light of the absence of suitable placebo controlled trials. Whilst continuous high dose progestagen (medroxy-progesterone acetate) appears to be effective, luteal phase dydrogesterone is no more effective than placebo.

Implications for research

There is little data relating to the use of progestagens in the treatment of endometriosis. These drugs are relatively cheap and trials assessing both their efficacy, cost effectiveness and effectiveness relative to alternative therapies are required. These drugs may also offer the opportunity for prolonged therapy (not appropriate with danazol and gonadotrophin releasing hormone analogues alone) and this also requires investigation.

The major deficiency in trials relating to gestrinone is the absence of a placebo controlled study.

No data is available comparing either treatment with surgical modalities. In the design of any future studies care should be taken not to obscure valuable data by confounding outcomes by alternate interventions at time of diagnosis.

AUTHORS' CONCLUSIONS

Implications for practice

It would appear that both continuous progestogens and the anti-

ACKNOWLEDGEMENTS

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* Indicates the major publication for the study

CHARACTERISTICS OF STUDIES

Characteristics of included studies [ordered by study ID]

Bromham 1995

Methods	Randomised double blind multi-centre study Method of randomisation not described Pharmaceutical company stated
Participants	269 British women aged 18-45 Inclusion criteria: endometriosis confirmed by laparoscopy or laparotomy. Exclusion criteria: those requiring surgical excision, serious systemic disease, those requiring long term treatment, previous failure of danazol treatment, other hormonal treatment within 2 months, unwillingness to use mechanical contraception.
Interventions	1. Gestrinone 2.5mg twice weekly plus 'dummy' danazol for 6 months (132 women) 2. Danazol 200mg bd plus 'dummy' gestrinone for 6 months (137 women) Duration of treatment: 6 months
Outcomes	American Fertility Society (AFS) scores at laparoscopy following 6 months treatment Pain scores during treatment and 1 year follow up Side effects Fertility
Notes	Repeat laparoscopy 23 days (median) after end of treatment Follow up: 12 months 5 patients became pregnant before commencing treatment 69 withdrew during treatment 50 withdrew from follow up phase

Risk of bias

Item	Authors' judgement	Description
Allocation concealment?	Yes	A - Adequate

Fedele 1989

Methods	Open randomised trial No source of funding stated
Participants	39 Italian women aged 23-35 Inclusion criteria: Infertility, laparoscopic diagnosis of endometriosis in preceding 3 months. Exclusion criteria: bilateral tubal occlusion, severe dyspermia in partner, use of danazol or other sex steroids in preceding 6 months, severe systemic or endocrine disease.

Fedele 1989 (Continued)

Interventions	1. Gestrinone 2.5 mg twice weekly (20 women) increasing to 3 times a week if no amenorrhoea by 1 month (7 of the 20) 2. Danazol 600mg per day (19 women) increasing to 800mg per day if no amenorrhoea by 1 month (2 of the 19) Duration of treatment : 6 months
Outcomes	Revised American Fertility Society (rAFS) scores at laparoscopy 1 month after end of treatment. Pain scores during treatment and 18 month follow up Plasma hormone levels before and during treatment Pregnancy rates post treatment Side effects
Notes	Only 7 gestrinone and 9 danazol patients had repeat laparoscopy Follow up: 12 months Losses to follow up : 1

Risk of bias

Item	Authors' judgement	Description
Allocation concealment?	No	C - Inadequate

GISG 1996

Methods	Randomised double blind double dummy multicentre trial Method of randomisation described Pharmaceutical company stated
Participants	55 Italian women aged 18-40 Inclusion criteria: chronic pelvic pain, laparoscopic diagnosis of endometriosis with no attempts at endometriosis reduction other than biopsy up to 3 months before study entry, no medical or surgical treatment for endometriosis between laparoscopy and study entry, not wanting pregnancies in the immediate future. Exclusion criteria: Treatment for endometriosis other than non steroidal anti inflammatory drugs in the previous 6 months, concomitant pelvic pain causing disorders, contraindications to the use of gestrinone or GnRH analogues, abnormal baseline bone density values, unwillingness to use barrier contraception.
Interventions	1. Gestrinone 2.5 mg twice weekly plus placebo injections (27 women) 2. IM leuprolide acetate 3.75mg once a month plus placebo tablets (28 women) Duration of treatment: 6 months
Outcomes	Pain symptoms Bone mineral density Lipid profile

Notes	Follow up: 6 months 6 withdrawals during treatment period 7 lost to follow up 8 pregnancies	
<i>Risk of bias</i>		
Item	Authors' judgement	Description
Allocation concealment?	Yes	A - Adequate

Hornstein 1990

Methods	Randomised double blind trial Pharmaceutical company stated	
Participants	12 American women Inclusion criteria: endometriosis (stage 2-3 disease according to revised American Fertility Society classification) diagnosed on videotaped laparoscopy within previous 6 weeks Exclusion criteria: none specified	
Interventions	1. Gestrinone 1.25mg twice weekly (6 women) 2 .Gestrinone 2.5mg twice weekly (6 women) Duration of treatment : 6 months	
Outcomes	Revised American Fertility Society (rAFS) scores of endometriosis at laparoscopy following treatment. Symptom scores during treatment and follow up Side effects Bone densitometry Hormonal, lipoprotein, haematological and biochemical measurements	
Notes	Second laparoscopy within 4 weeks of completing treatment Follow up : 6 months Losses to follow up: 2	
<i>Risk of bias</i>		
Item	Authors' judgement	Description
Allocation concealment?	Yes	A - Adequate

Overton 1994

Methods	Double blind randomised multicentre study Randomisation method stated Pharmaceutical company stated
Participants	62 British women aged 21-42 Inclusion criteria: minimal - mild endometriosis (American Fertility Society classification score 1-15, stage 1 or 2) diagnosed at laparoscopy within preceding 3 months, women with azoospermic partners who had had more than 12 cycles of unsuccessful donor insemination, women taking clomiphene citrate or cyclofenil for ovulation induction also included Exclusion criteria: Women taking corticosteroids, hormones, danazol, or GnRH agonists in month before admission to the study.
Interventions	1. 40mg dydrogesterone for 12 days starting 2 days after LH surge 2. 60mg dydrogesterone given as above 3. placebo given as above. Duration of treatment: 6 months
Outcomes	Conception rates Change in American Fertility Society (AFS) scores at laparoscopy following treatment Pain scores Bleeding
Notes	Follow up: 12 months Second laparoscopy within 3 months of completing treatment Exclusions post randomization: 5 never treated, 1 refused, 4 conceived Losses to follow-up: 23

Risk of bias

Item	Authors' judgement	Description
Allocation concealment?	Yes	A - Adequate

Telimaa 1987b

Methods	Double-blind double dummy single centre study. Randomisation method not clear.
Participants	59 participants aged 26-38 with mild to moderate endometriosis. No previous medical or surgical treatment. No exclusion criteria specified. 9 participants lost to follow-up

Telimaa 1987b (Continued)

Interventions	Danazol 200mg po tds Medroxyprogesterone acetate 100mg po daily Placebo All medications taken for 180 days	
Outcomes	Change in AFS scores Patient reported pain symptoms Side effects	
Notes	27% of patients had electro-coagulation of implants at initial diagnostic laparoscopy. 2nd look laparoscopy was performed 6 months after completion of treatment	
<i>Risk of bias</i>		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Vercellini 1996

Methods	Open randomised trial No source of fundng stated
Participants	80 Italian women aged 18-40 Inclusion criteria: first diagnosis of endometriosis at laparoscopy with attempt at implant reduction other than biopsy in the previous 3 months, pelvic pain of greater than 6 months duration Exclusion criteria: treatment for endometriosis other than non steroidal antiinflammatory drugs in preceding 3 months, contraindications to taking oestrogens, progestagens or danazol, a desire to conceive in the next 2 years
Interventions	1. Depot medroxyprogesterone acetate 150mg every 90 days 2. oral contraceptive pill (ethinylestradiol 0.02mg + desogestrel0.15mg) plus 50mg danazol daily for 21 days out of 28 Duration of treatment: 12 months
Outcomes	Pain scores Side effects Fasting cholesterol, HDL, LDL 17 beta oestradiol (in medroxyprogesterone acetate group)
Notes	Follow up : no post treatment follow up 11 withdrawals 1 lost to follow up
<i>Risk of bias</i>	

Vercellini 1996 *(Continued)*

Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Characteristics of excluded studies *[ordered by study ID]*

Dawood 1997	Pain data not reported separately for the two groups. Relief of pain was not a primary endpoint.
Mettler 1987	The “three step” therapy discussed in this study is a mixture of surgical and medical therapy
Nieto 1996	23/25 patients on gestrinone and 18/18 patients on danazol had surgery prior to medical treatment.
Noble 1980	Comparison of danazol with oral contraceptive pill
Telimaa 1987a	Patients were recruited to the study following surgical treatment.
Thomas 1987a	This study does not have relief of pain as an outcome measure, it concentrates on effects on fertility.
Worthington 1993	Relief of pain is not an outcome considered in this study.

Characteristics of studies awaiting assessment *[ordered by study ID]***Halbe**

Methods	Not completed by review author
Participants	
Interventions	
Outcomes	
Notes	

DATA AND ANALYSES

Comparison 2. DYDROGESTERONE VS PLACEBO

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Subjective efficacy of 40mg dose at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
1.1 pain improved	1	22	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.70 [0.13, 3.68]
1.2 no change in pain	1	22	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.21 [0.39, 26.67]
1.3 pain worse	1	22	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.70 [0.13, 3.68]
2 Subjective efficacy of 60mg dose at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
2.1 pain improved	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.60 [0.48, 14.06]
2.2 no change in pain	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.34 [0.21, 25.45]
2.3 pain worse	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.19 [0.03, 1.22]
3 Subjective efficacy of 40mg dose at end of follow-up (18 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
3.1 pain improved	1	40	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.84 [0.24, 2.87]
3.2 no change in pain	1	40	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.90 [0.12, 6.92]
3.3 pain worse	1	40	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.42 [0.54, 21.79]
4 Subjective efficacy of 60mg dose at end of follow-up (18 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
4.1 pain improved	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.94 [0.49, 7.59]
4.2 no change in pain	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.17 [0.01, 2.88]
4.3 pain worse	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.38 [0.08, 23.79]
5 Objective efficacy of 40mg dose at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
5.1 AFS scores improved	1	29	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.88 [0.21, 3.68]
5.2 no change in AFS scores	1	29	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.68 [0.10, 4.52]
5.3 AFS score worse	1	29	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.50 [0.32, 7.06]
6 Objective efficacy of 60mg dose at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
6.1 AFS scores improved	1	25	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.26 [0.05, 1.31]
6.2 no change in AFS scores	1	25	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.76 [0.70, 20.17]
6.3 AFS score worse	1	25	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.17 [0.20, 6.72]

Comparison 3. DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Subjective efficacy at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
1.1 pain improved	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.61 [0.68, 19.25]
1.2 no change in pain	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.68 [0.10, 4.86]
1.3 pain worse	1	21	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.25 [0.04, 1.78]
2 Subjective efficacy at end of follow-up (18 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
2.1 pain improved	1	35	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.30 [0.61, 8.73]
2.2 no change in pain	1	35	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.18 [0.01, 3.17]
2.3 pain worse	1	35	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.39 [0.06, 2.61]
3 Objective efficacy at end of treatment (6 months)	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
3.1 AFS scores improved	1	24	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.29 [0.06, 1.51]
3.2 no change in AFS scores	1	24	Peto Odds Ratio (Peto, Fixed, 95% CI)	5.24 [0.91, 30.10]
3.3 AFS score worse	1	24	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.78 [0.14, 4.22]

Comparison 4. MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Patient assessed efficacy during and at end of treatment (6 and 12 months)			Other data	No numeric data
1.1 painful periods, visual analogue scale			Other data	No numeric data
1.2 painful periods, verbal rating scale			Other data	No numeric data
1.3 pain on intercourse, visual analogue scale			Other data	No numeric data
1.4 pain on intercourse, verbal rating scale			Other data	No numeric data
1.5 non-menstrual pain, visual analogue scale			Other data	No numeric data
1.6 non-menstrual pain, verbal rating scale			Other data	No numeric data
2 Side effects	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
2.1 acne/greasy skin (seborrhoea)	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.87 [1.04, 14.46]
2.2 hot flushes	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.98 [0.20, 19.62]
2.3 breast pain/tension	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.23 [0.35, 4.36]
2.4 headaches	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.30 [0.48, 3.56]
2.5 nausea	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	3.44 [1.16, 10.21]

2.6 dizziness	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.39 [0.15, 372.38]
2.7 weight gain	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.50 [1.03, 6.06]
2.8 amenorrhoea	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	8.98 [2.10, 38.33]
2.9 breakthrough bleeding/ spotting	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	16.33 [6.80, 39.19]
2.10 bloating	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	4.04 [1.68, 9.70]
2.11 depression	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.18 [0.39, 3.59]
2.12 asthenia	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.01 [0.06, 16.27]
2.13 peripheral oedema	1	80	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.98 [0.20, 19.62]

Comparison 5. MEDROXYPROGESTERONE ACETATE VS PLACEBO

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.1 pelvic pain	1	33	Mean Difference (IV, Fixed, 95% CI)	-1.04 [-1.63, -0.97]
1.2 sum of all symptoms	1	33	Mean Difference (IV, Fixed, 95% CI)	-5.20 [-6.80, -3.60]
2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
2.1 pelvic pain	1	29	Mean Difference (IV, Fixed, 95% CI)	-0.85 [-1.19, -0.51]
2.2 sum of all symptoms	1	29	Mean Difference (IV, Fixed, 95% CI)	-7.01 [-8.61, -5.39]
3 Objective efficacy at end of follow up (12 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
3.1 AFS score	1	33	Mean Difference (IV, Fixed, 95% CI)	-0.58 [-1.41, 0.25]
4 Side effects	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
4.1 acne	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	6.26 [1.21, 32.43]
4.2 oedema	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	13.94 [3.45, 56.37]
4.3 muscle cramps	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	9.03 [0.87, 93.55]
4.4 spotting	1	33	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.64 [0.58, 11.94]

Comparison 6. MEDROXYPROGESTERONE ACETATE VS DANAZOL

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.1 pelvic pain	1	34	Mean Difference (IV, Fixed, 95% CI)	0.10 [-0.26, 0.46]
1.2 sum of all symptoms	1	34	Mean Difference (IV, Fixed, 95% CI)	0.50 [-1.10, 2.10]
2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only

2.1 pelvic pain	1	32	Mean Difference (IV, Fixed, 95% CI)	0.23 [-0.11, 0.57]
2.2 sum of all symptoms	1	32	Mean Difference (IV, Fixed, 95% CI)	-3.05 [-4.83, -1.97]
3 Objective efficacy at end of follow up (12 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
3.1 AFS score	1	31	Mean Difference (IV, Fixed, 95% CI)	0.06 [-0.82, 0.94]
4 Side effects	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
4.1 acne	1	34	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.40 [0.11, 1.51]
4.2 oedema	1	34	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.60 [0.68, 9.91]
4.3 muscle cramps	1	34	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.48 [0.11, 2.17]
4.4 spotting	1	34	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.54 [0.37, 6.36]

Comparison 10. GESTRINONE VS DANAZOL

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Patient assessed efficacy at end of treatment (6 months)	2		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
1.1 none or mild pelvic pain	2	230	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.72 [0.33, 1.55]
1.2 none or mild painful periods (dysmenorrhoea)	2	214	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.72 [0.39, 1.33]
1.3 none or mild pain on on intercourse (dyspareunia)	2	222	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.83 [0.37, 1.85]
2 Patient assessed efficacy 6 months after the end of treatment.	2		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
2.1 none or mild pelvic pain	2	202	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.20 [0.58, 2.48]
2.2 none or mild painful periods (dysmenorrhoea)	2	176	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.03 [0.55, 1.93]
2.3 none or mild pain on on intercourse (dyspareunia)	2	192	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.94 [0.42, 2.09]
3 Objective assessment of efficacy at end of treatment (6 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
3.1 rAFS scores	1	16	Mean Difference (IV, Fixed, 95% CI)	1.40 [-6.76, 9.56]
3.2 implant score	1	16	Mean Difference (IV, Fixed, 95% CI)	1.10 [-6.28, 8.48]
4 Side effects	2		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
4.1 acne	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.45 [0.90, 2.32]
4.2 seborrhoea	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.68 [1.67, 4.31]
4.3 hirsutism	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.63 [1.62, 4.28]
4.4 voice problems	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.69 [0.34, 1.42]
4.5 swelling hands/feet	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.40 [0.82, 2.37]
4.6 hot flushes	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.79 [0.49, 1.26]
4.7 sweating problems	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.44 [0.88, 2.34]
4.8 loss of libido	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.32 [0.80, 2.18]
4.9 decreased breast size	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.62 [0.39, 0.98]
4.10 leg or muscle cramps	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.49 [0.31, 0.78]
4.11 headaches	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.36 [0.84, 2.20]
4.12 nausea	2	302	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.36 [0.84, 2.18]
4.13 vomiting	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.68 [0.32, 1.41]
4.14 loss of appetite	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.31 [0.72, 2.36]

4.15 hunger	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.59 [0.36, 0.97]
4.16 dizziness	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.24 [0.75, 2.05]
4.17 tiredness	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.43 [0.84, 2.43]
4.18 faintness	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.23 [0.55, 2.75]
4.19 skin rash	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.70 [0.92, 3.14]
4.20 weight gain	1	38	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.35 [0.10, 1.25]
4.21 vaginal dryness	1	38	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.13 [0.01, 2.13]
4.22 raised liver transaminases	1	38	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.13 [0.01, 2.13]
4.23 stopped treatment because of side effects	1	264	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.86 [0.47, 1.57]

Comparison 11. GESTRINONE VS GnRH ANALOGUE

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Patient assessed efficacy at end of treatment (6 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
1.1 painful periods, visual analogue scale	1	55	Mean Difference (IV, Fixed, 95% CI)	0.83 [0.15, 1.49]
1.2 painful periods, verbal rating scale	1	55	Mean Difference (IV, Fixed, 95% CI)	0.35 [0.12, 0.58]
1.3 pain on intercourse, visual analogue scale	1	52	Mean Difference (IV, Fixed, 95% CI)	-1.16 [-2.08, -0.24]
1.4 pain on intercourse, verbal rating scale	1	52	Mean Difference (IV, Fixed, 95% CI)	-0.33 [-0.62, -0.04]
1.5 non-menstrual pain, visual analogue scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-0.41 [-1.76, 0.94]
1.6 non-menstrual pain, verbal rating scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-0.15 [-0.50, 0.20]
2 Patient assessed efficacy at end of follow-up (12 months)	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
2.1 painful periods, visual analogue scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-3.01 [-4.79, -1.21]
2.2 painful periods, verbal rating scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-0.94 [-1.50, -0.38]
2.3 pain on intercourse, visual analogue scale	1	52	Mean Difference (IV, Fixed, 95% CI)	-2.34 [-3.66, -1.02]
2.4 pain on intercourse, verbal rating scale	1	52	Mean Difference (IV, Fixed, 95% CI)	-0.55 [-0.94, -0.14]
2.5 non-menstrual pain, visual analogue scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-2.04 [-3.70, -0.90]
2.6 non-menstrual pain, verbal rating scale	1	55	Mean Difference (IV, Fixed, 95% CI)	-0.83 [-1.24, -0.42]
3 Side effects	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
3.1 hot flushes	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.22 [0.08, 0.64]
3.2 headaches	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.40 [0.08, 1.91]
3.3 asthenia	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.80 [0.20, 3.31]
3.4 mood changes	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.68 [0.11, 4.18]

3.5 dermatitis	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	8.29 [0.83, 83.27]
3.6 dizziness	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.08 [0.21, 20.84]
3.7 joint pain	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.08 [0.21, 20.84]
3.8 drowsiness	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	2.08 [0.21, 20.84]
3.9 swelling	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.97 [0.49, 130.81]
3.10 nausea	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.04 [0.06, 17.04]
3.11 tachycardia	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	1.04 [0.06, 17.04]
3.12 vaginal dryness	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.01, 2.22]
3.13 insomnia	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.67 [0.15, 386.69]
3.14 hypertrichosis	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.67 [0.15, 386.69]
3.15 seborrhoea	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.67 [0.15, 386.69]
3.16 skin rash	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.67 [0.15, 386.69]
3.17 constipation	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.67 [0.15, 386.69]
3.18 itching	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.00, 7.07]
3.19 vaginal discharge	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.00, 7.07]
3.20 paraesthesia	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.00, 7.07]
3.21 cramps	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.00, 7.07]
4 Suffered any side-effect	1	55	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.60 [0.20, 1.76]
5 Amenorrhoeic during treatment	1	49	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.10 [0.03, 0.35]
6 Spotting or bleeding during treatment	1	49	Peto Odds Ratio (Peto, Fixed, 95% CI)	10.28 [2.82, 37.38]

Comparison 12. GESTRINONE VS GESTRINONE (VARYING DOSAGE)

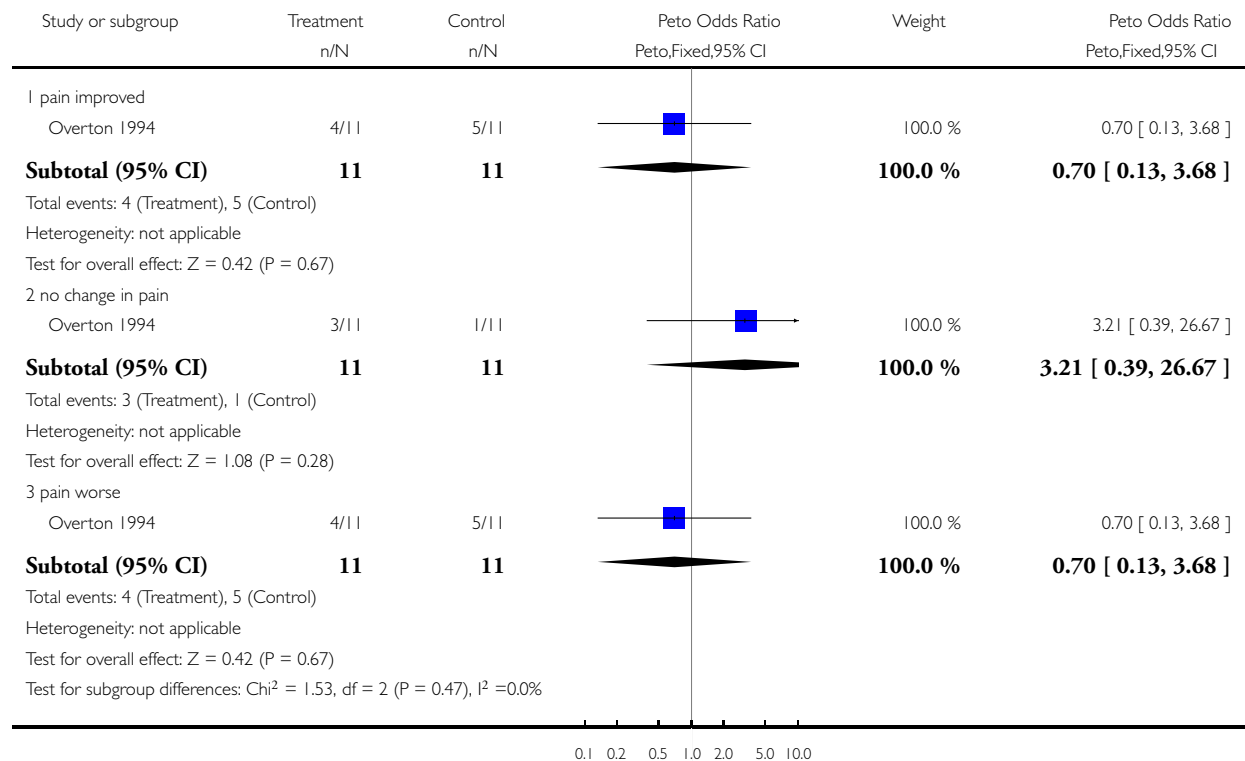
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Subjective improvement in pain	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
2 Objective efficacy -rAFS scores at 6 months	1		Mean Difference (IV, Fixed, 95% CI)	Subtotals only
3 Side effects	1		Peto Odds Ratio (Peto, Fixed, 95% CI)	Subtotals only
3.1 noted any side effect	1	12	Peto Odds Ratio (Peto, Fixed, 95% CI)	15.64 [1.57, 155.75]
3.2 discontinued treatment because of headaches	1	12	Peto Odds Ratio (Peto, Fixed, 95% CI)	7.39 [0.15, 372.38]
3.3 discontinued treatment because of continuing pain	1	12	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.14 [0.00, 6.82]
3.4 suffered from irregular bleeding	1	12	Peto Odds Ratio (Peto, Fixed, 95% CI)	0.44 [0.04, 5.40]

Analysis 2.1. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 1 Subjective efficacy of 40mg dose at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

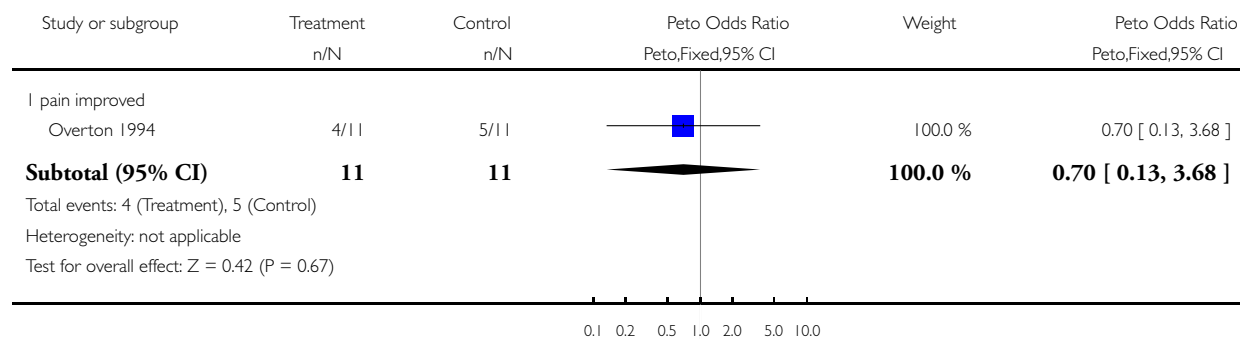
Outcome: 1 Subjective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

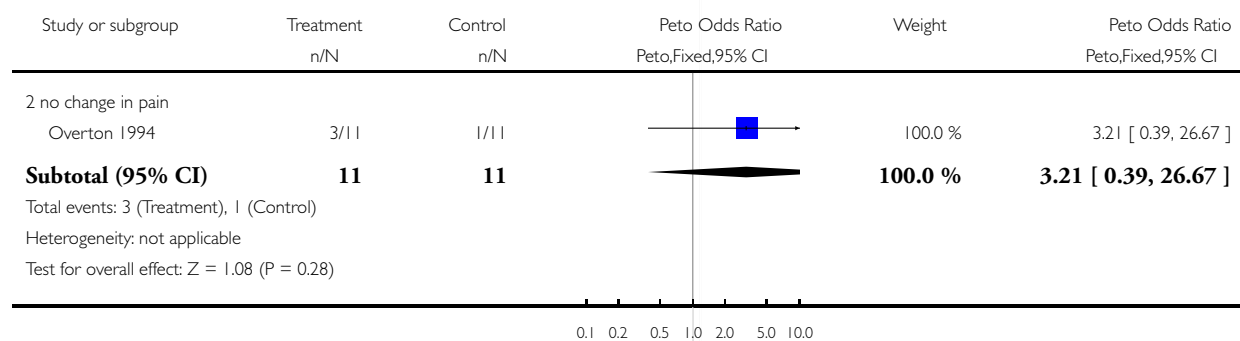
Outcome: 1 Subjective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

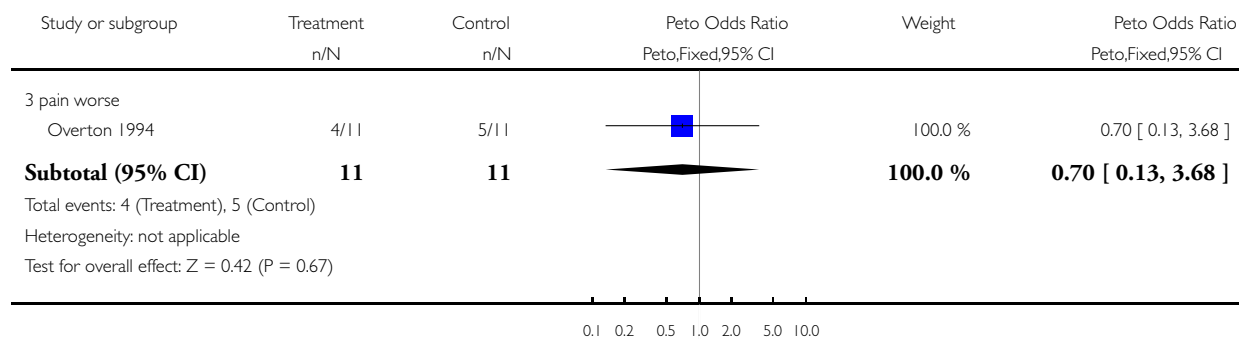
Outcome: 1 Subjective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 1 Subjective efficacy of 40mg dose at end of treatment (6 months)

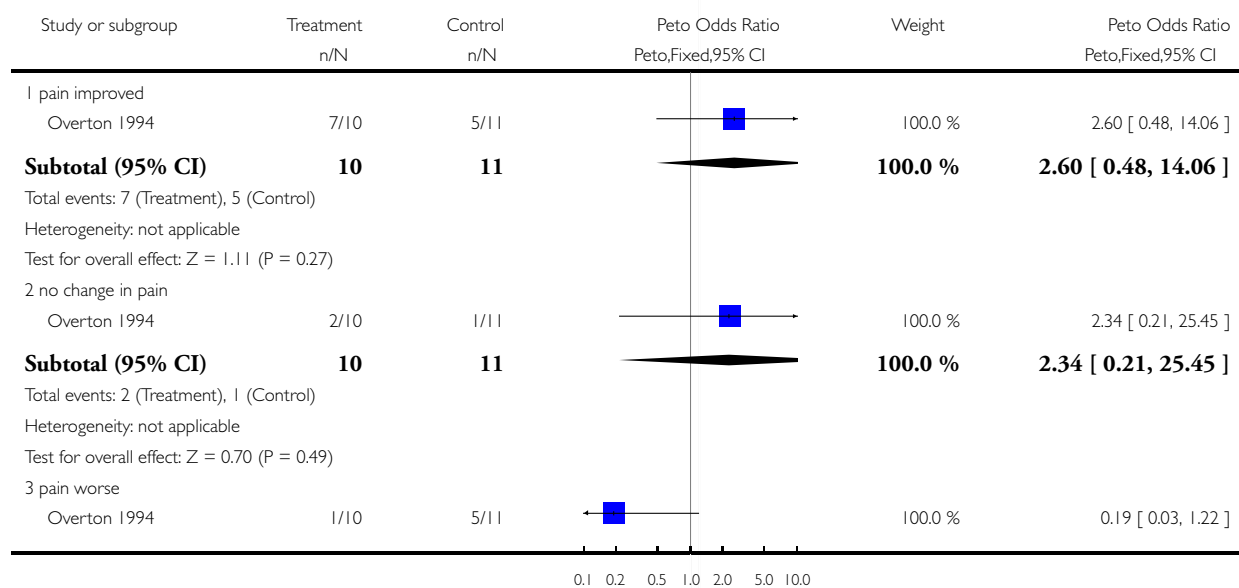


Analysis 2.2. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 2 Subjective efficacy of 60mg dose at end of treatment (6 months).

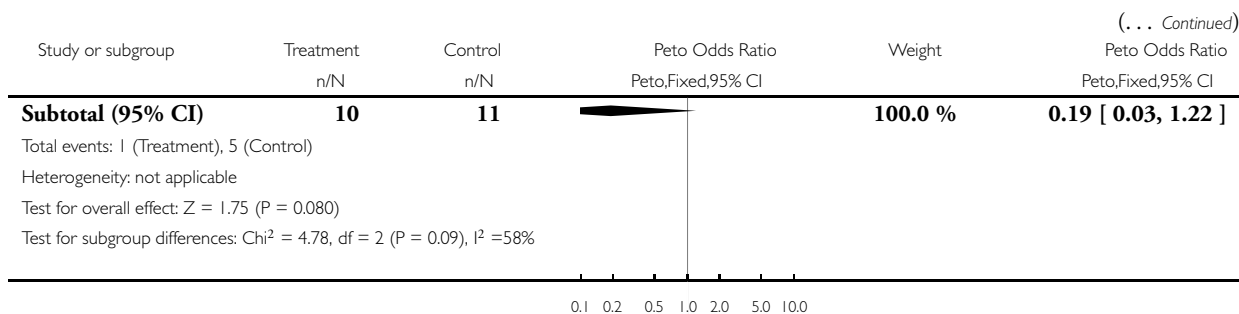
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 2 Subjective efficacy of 60mg dose at end of treatment (6 months)



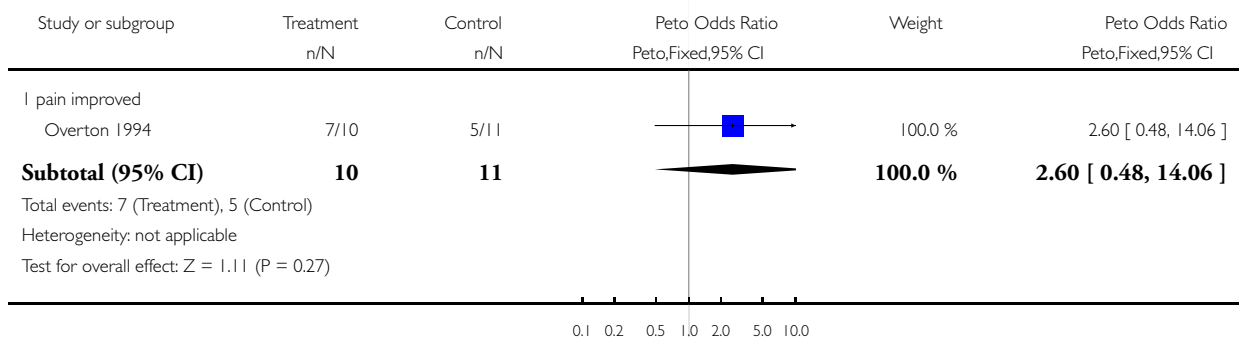
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

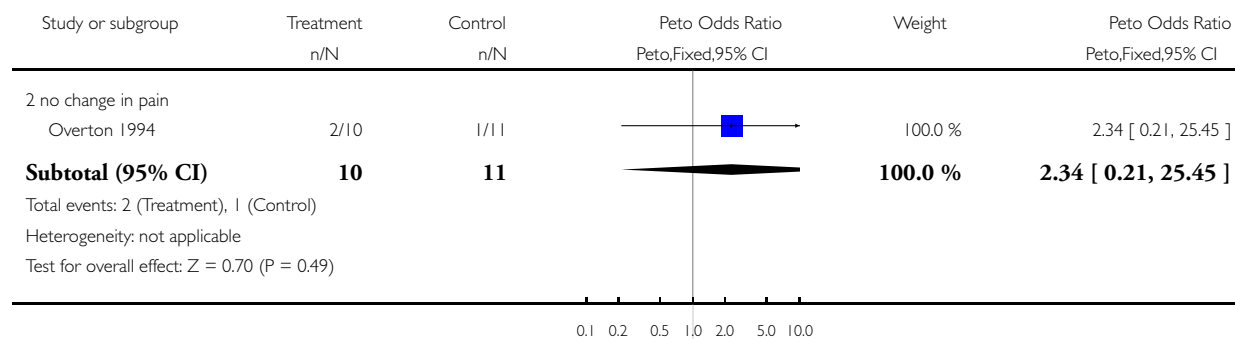
Outcome: 2 Subjective efficacy of 60mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

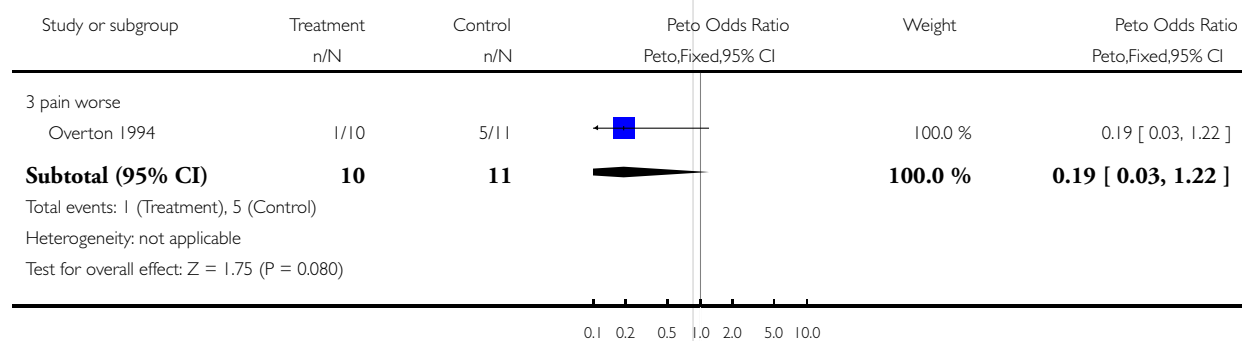
Outcome: 2 Subjective efficacy of 60mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 2 Subjective efficacy of 60mg dose at end of treatment (6 months)

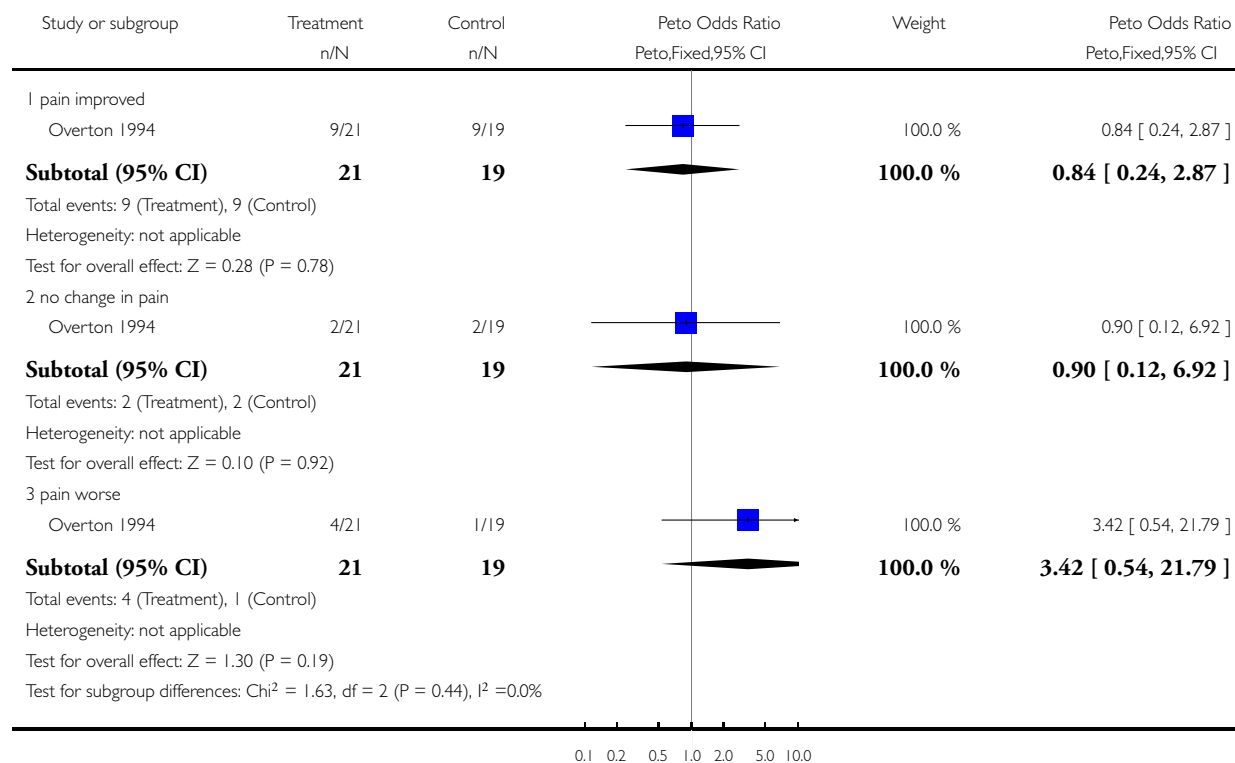


Analysis 2.3. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 3 Subjective efficacy of 40mg dose at end of follow-up (18 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

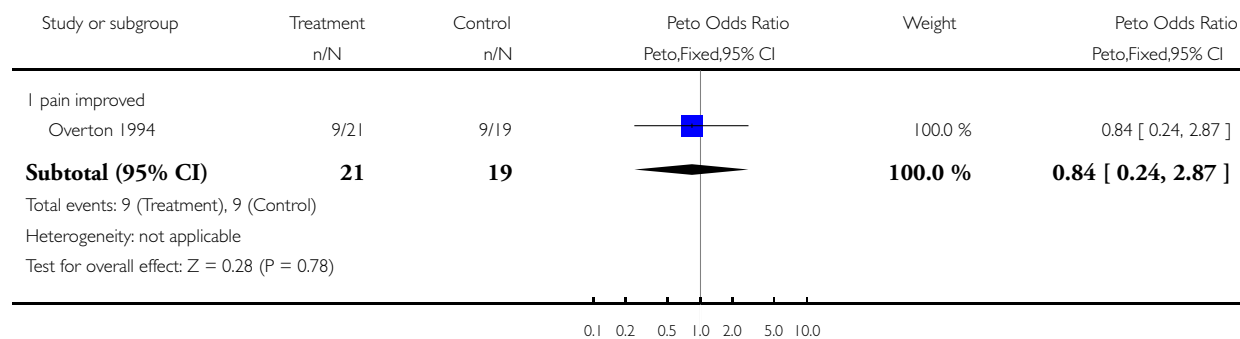
Outcome: 3 Subjective efficacy of 40mg dose at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

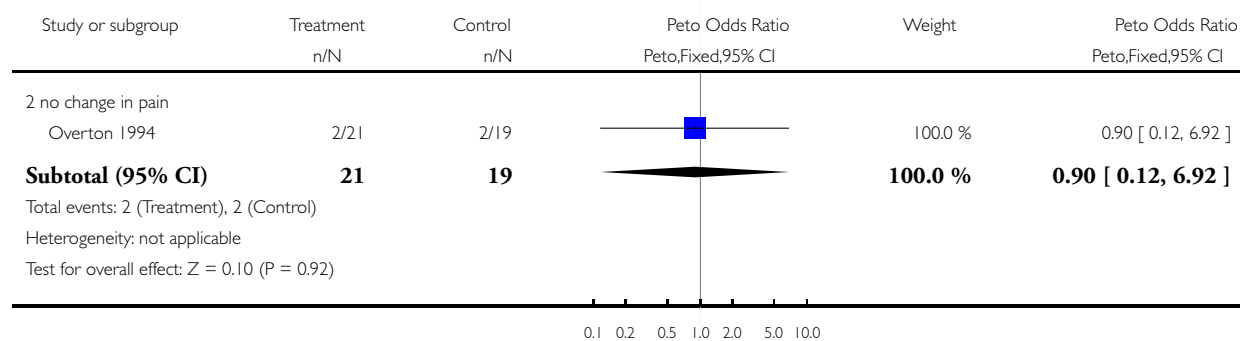
Outcome: 3 Subjective efficacy of 40mg dose at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

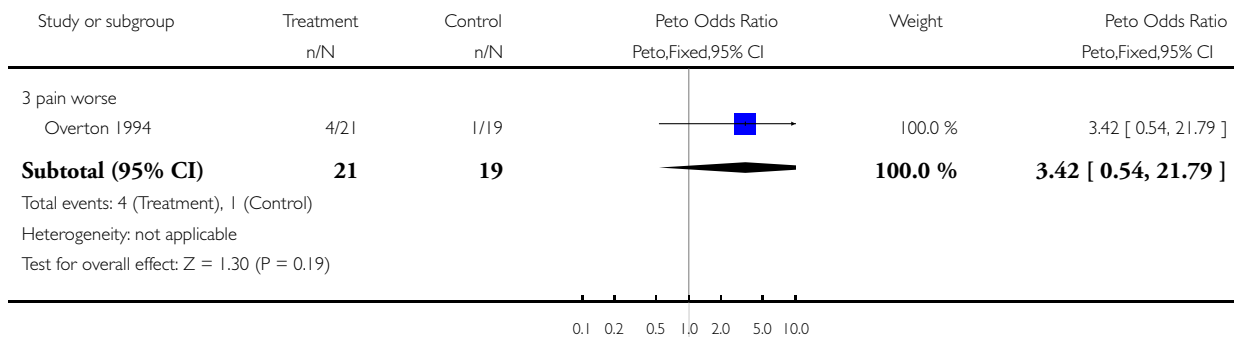
Outcome: 3 Subjective efficacy of 40mg dose at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 3 Subjective efficacy of 40mg dose at end of follow-up (18 months)

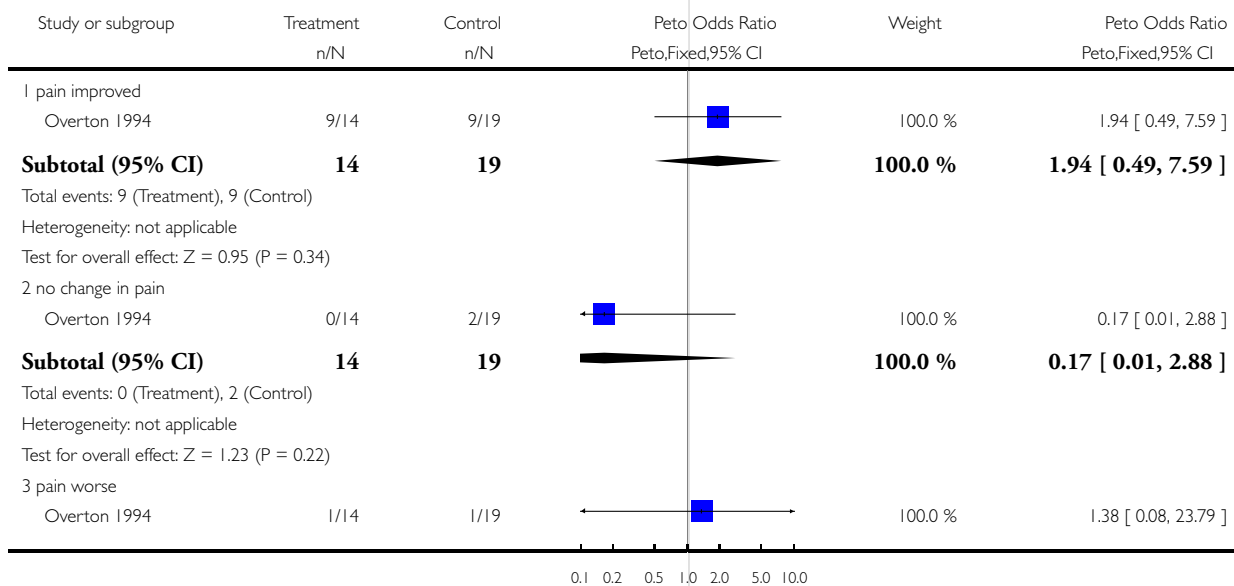


Analysis 2.4. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 4 Subjective efficacy of 60mg dose at end of follow-up (18 months).

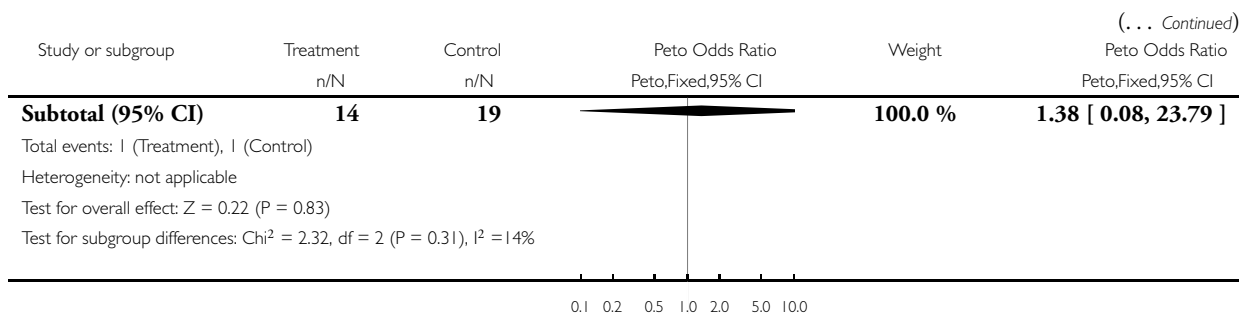
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 4 Subjective efficacy of 60mg dose at end of follow-up (18 months)



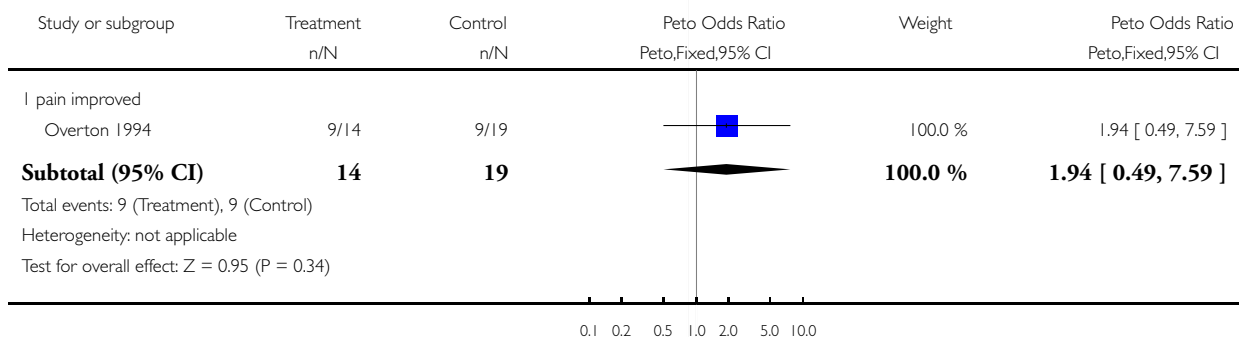
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

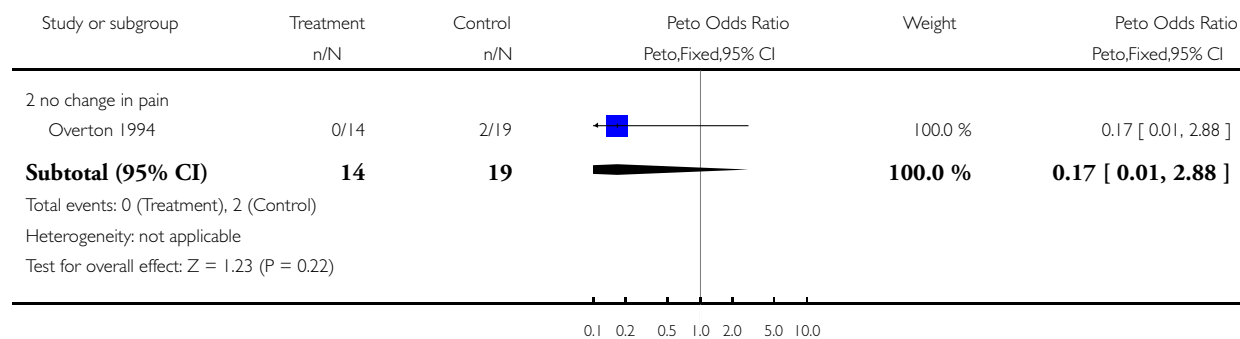
Outcome: 4 Subjective efficacy of 60mg dose at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

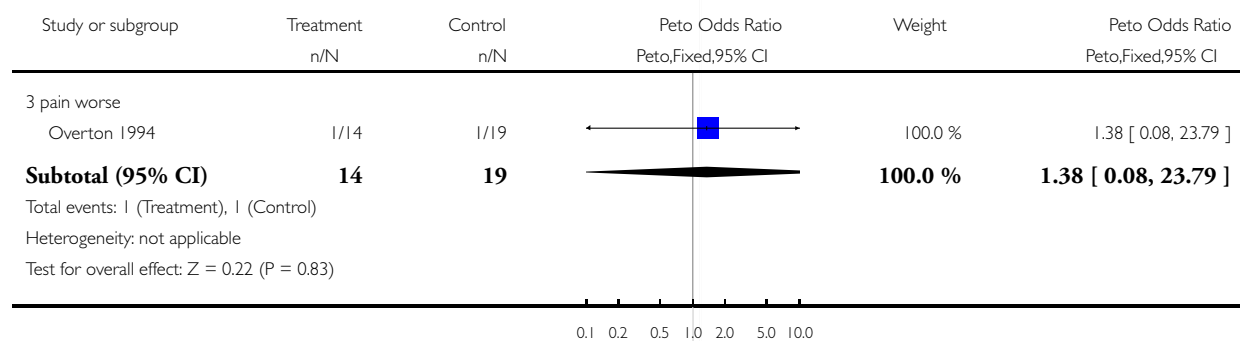
Outcome: 4 Subjective efficacy of 60mg dose at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 4 Subjective efficacy of 60mg dose at end of follow-up (18 months)

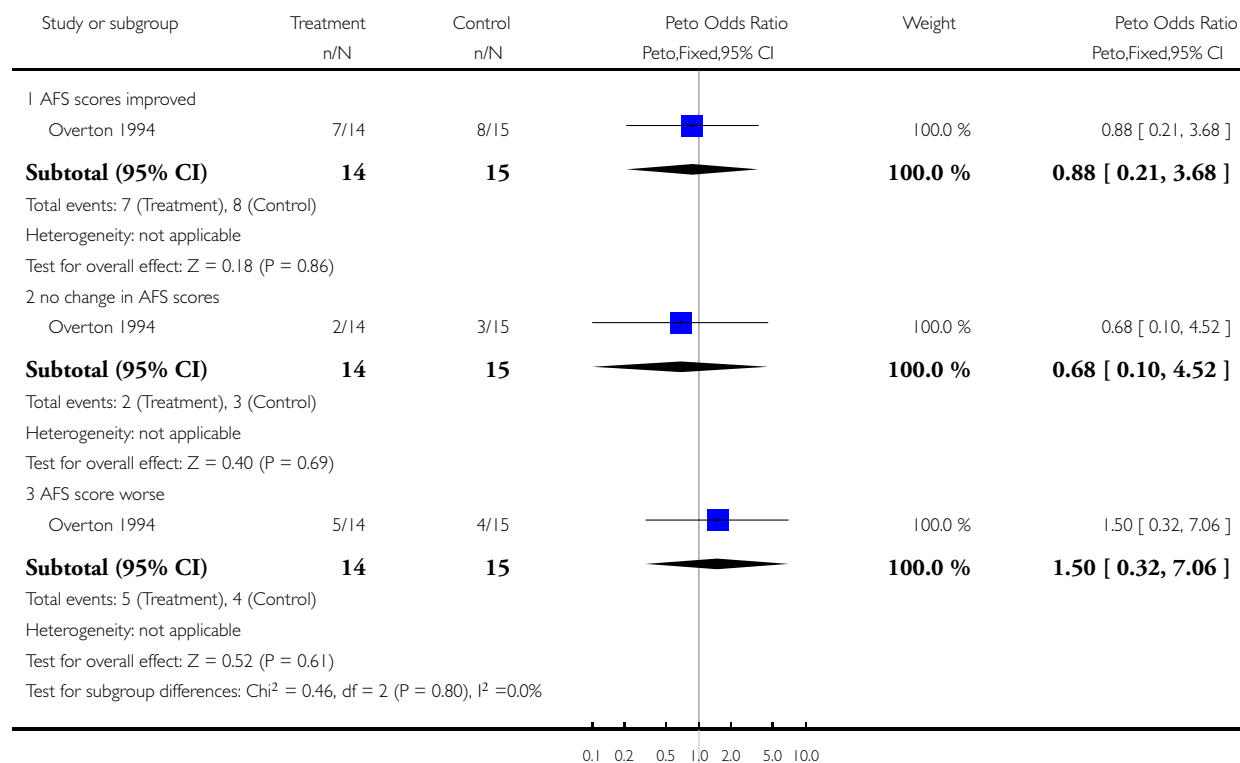


Analysis 2.5. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 5 Objective efficacy of 40mg dose at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

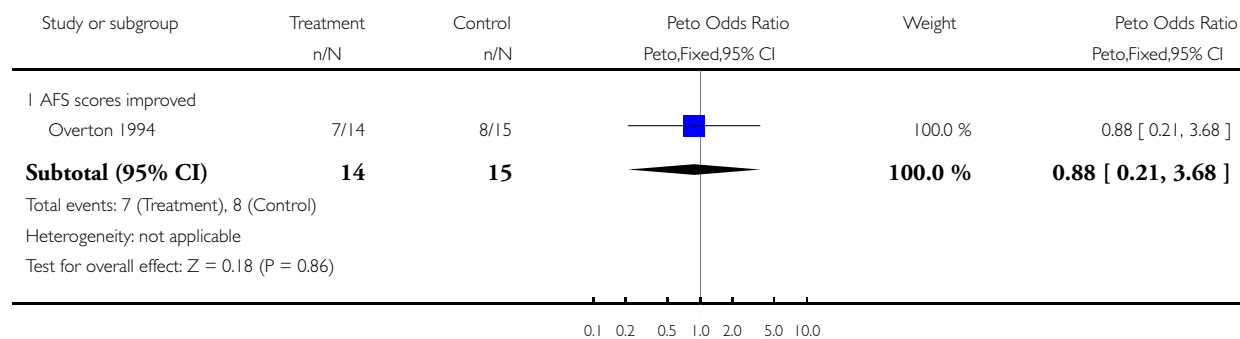
Outcome: 5 Objective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

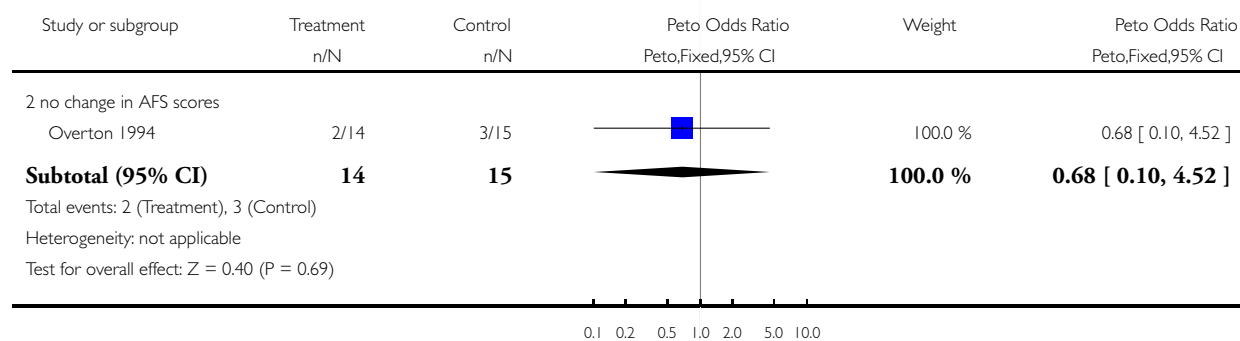
Outcome: 5 Objective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

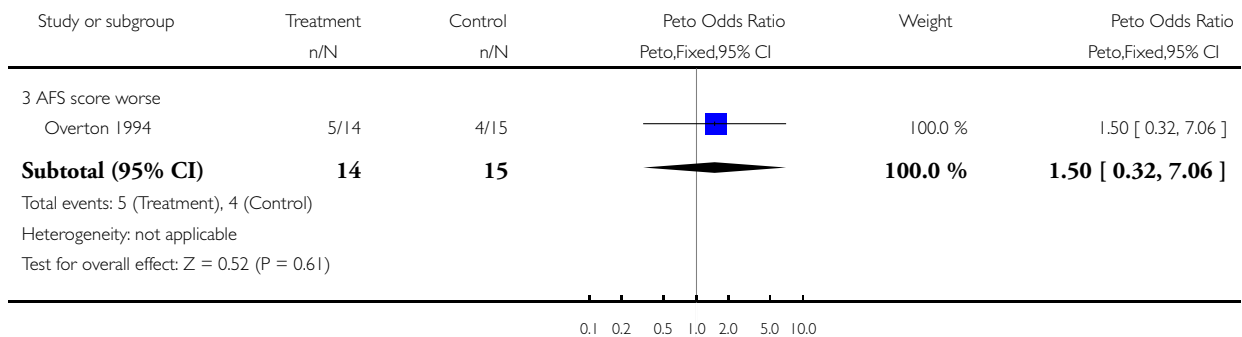
Outcome: 5 Objective efficacy of 40mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 5 Objective efficacy of 40mg dose at end of treatment (6 months)

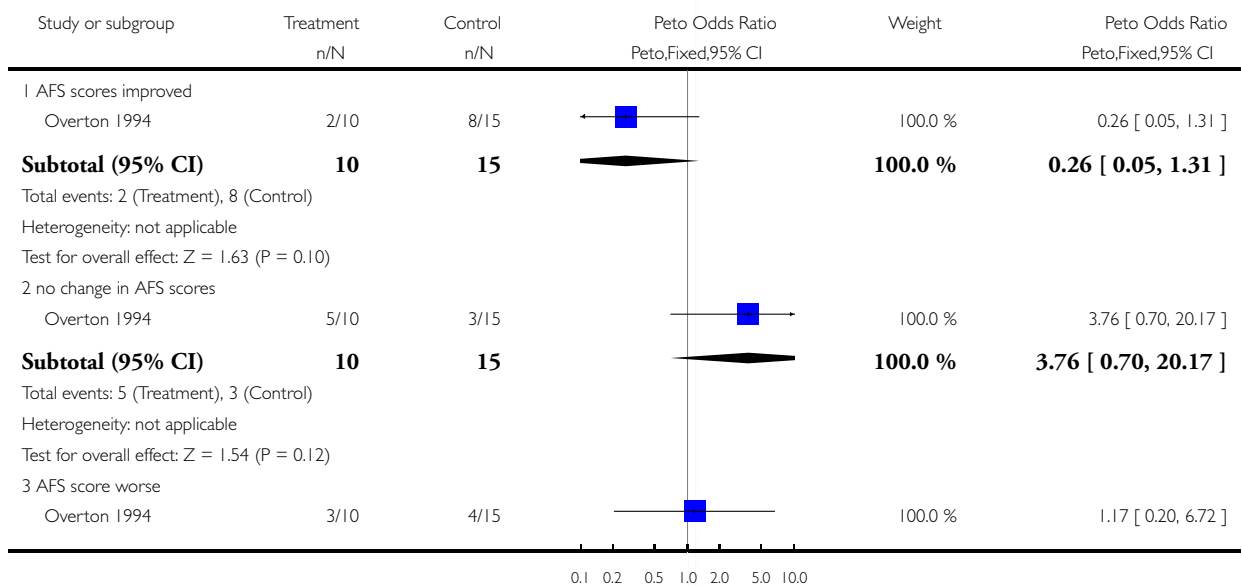


Analysis 2.6. Comparison 2 DYDROGESTERONE VS PLACEBO, Outcome 6 Objective efficacy of 60mg dose at end of treatment (6 months).

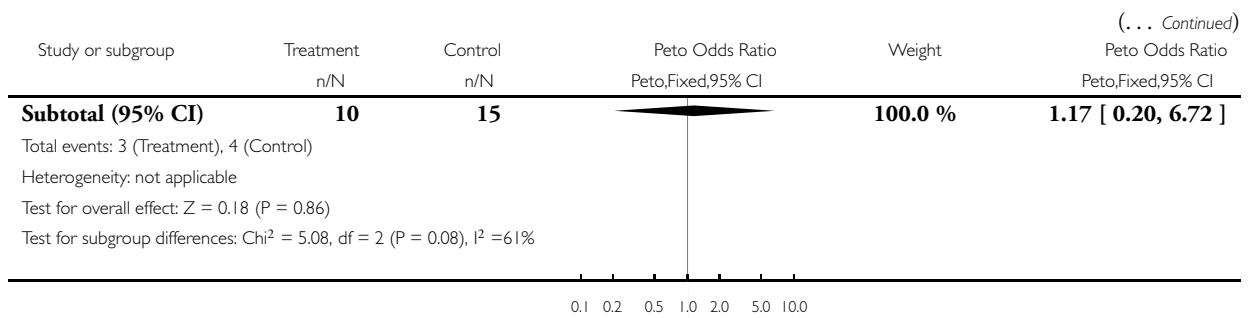
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 6 Objective efficacy of 60mg dose at end of treatment (6 months)



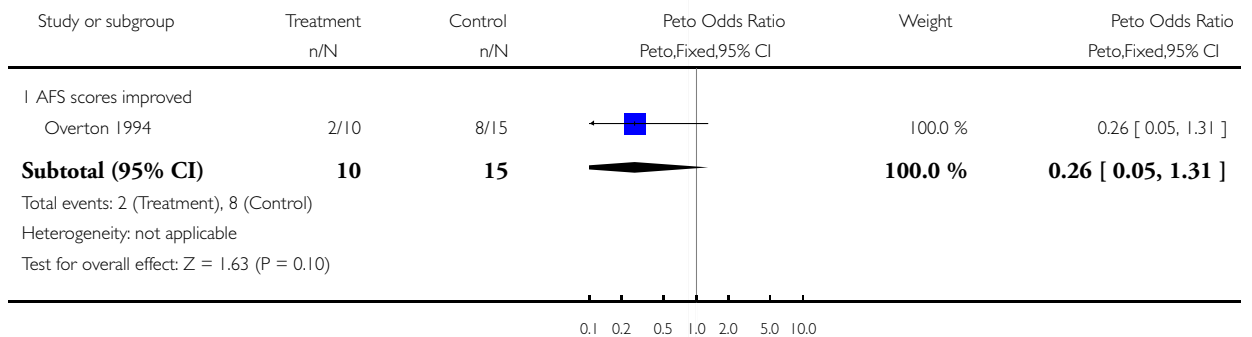
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

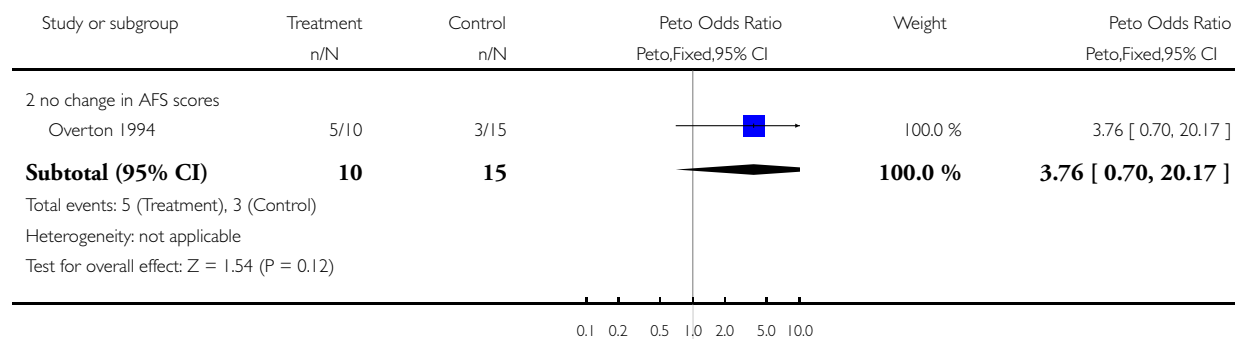
Outcome: 6 Objective efficacy of 60mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

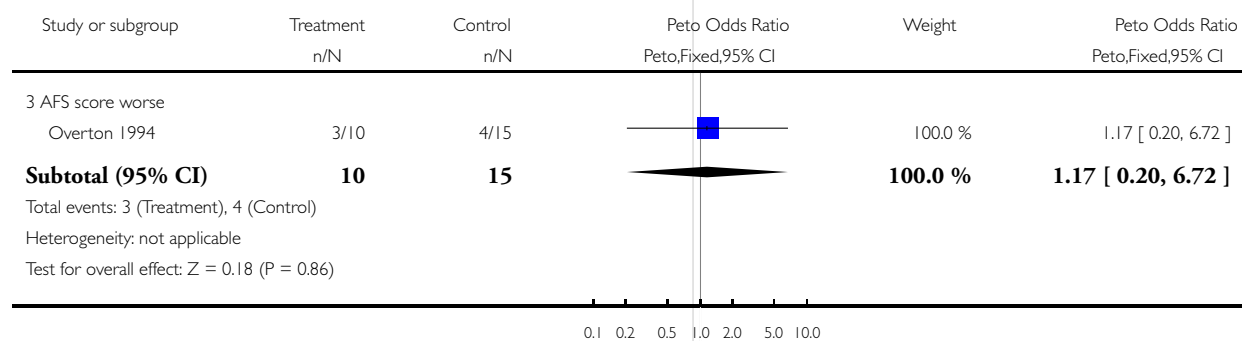
Outcome: 6 Objective efficacy of 60mg dose at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 2 DYDROGESTERONE VS PLACEBO

Outcome: 6 Objective efficacy of 60mg dose at end of treatment (6 months)

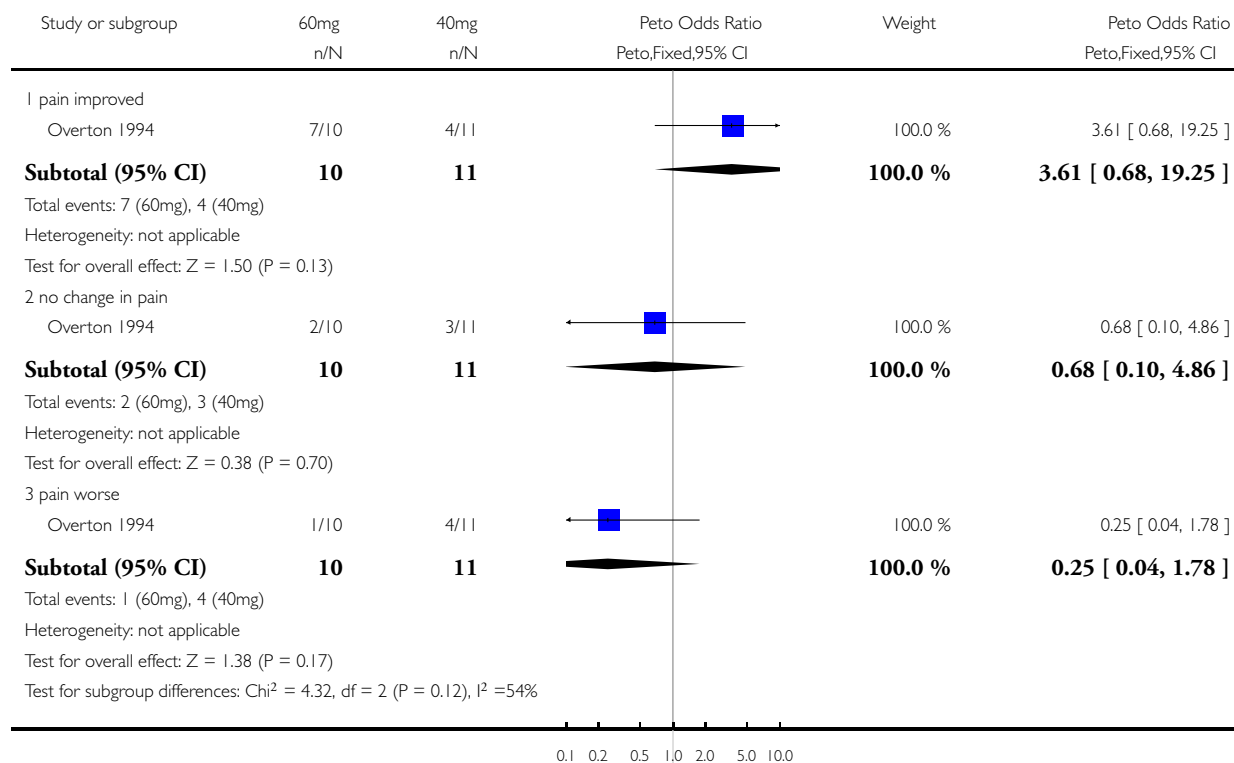


Analysis 3.1. Comparison 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG., Outcome 1 Subjective efficacy at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

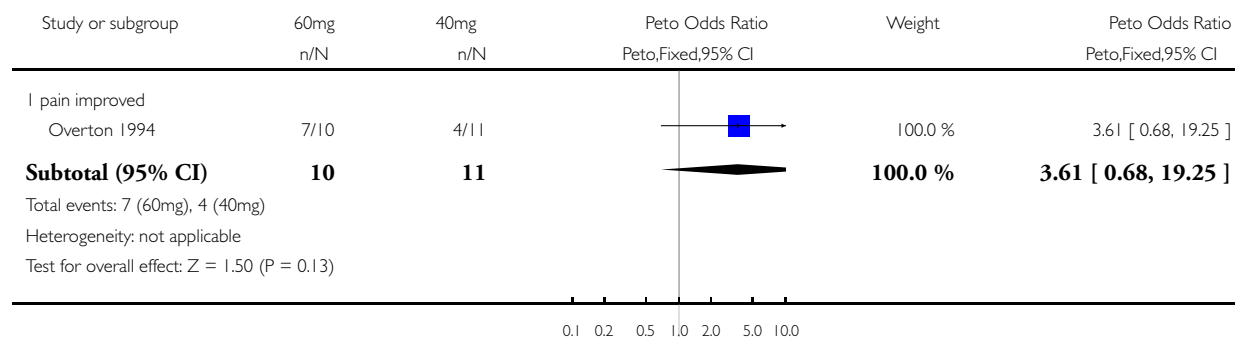
Outcome: 1 Subjective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

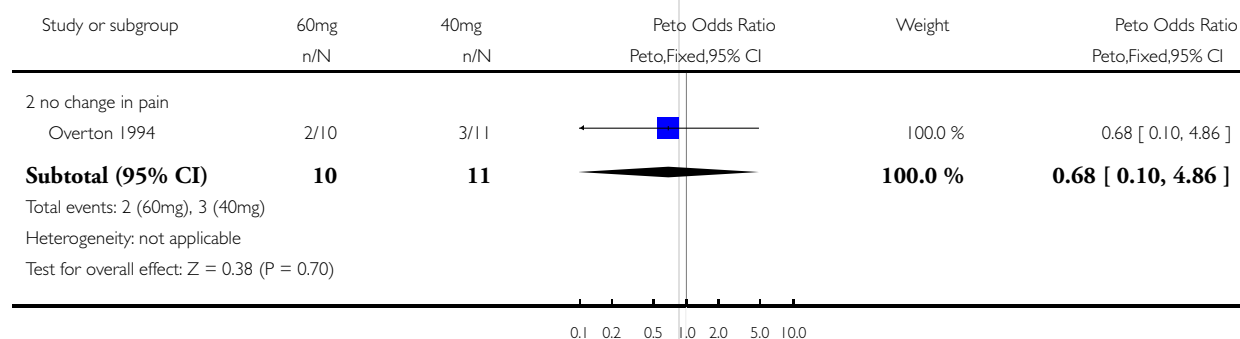
Outcome: 1 Subjective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

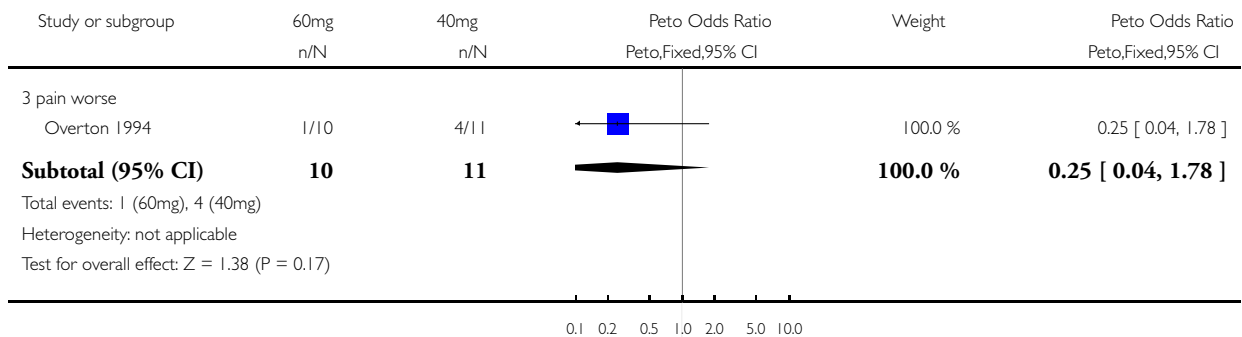
Outcome: 1 Subjective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

Outcome: 1 Subjective efficacy at end of treatment (6 months)

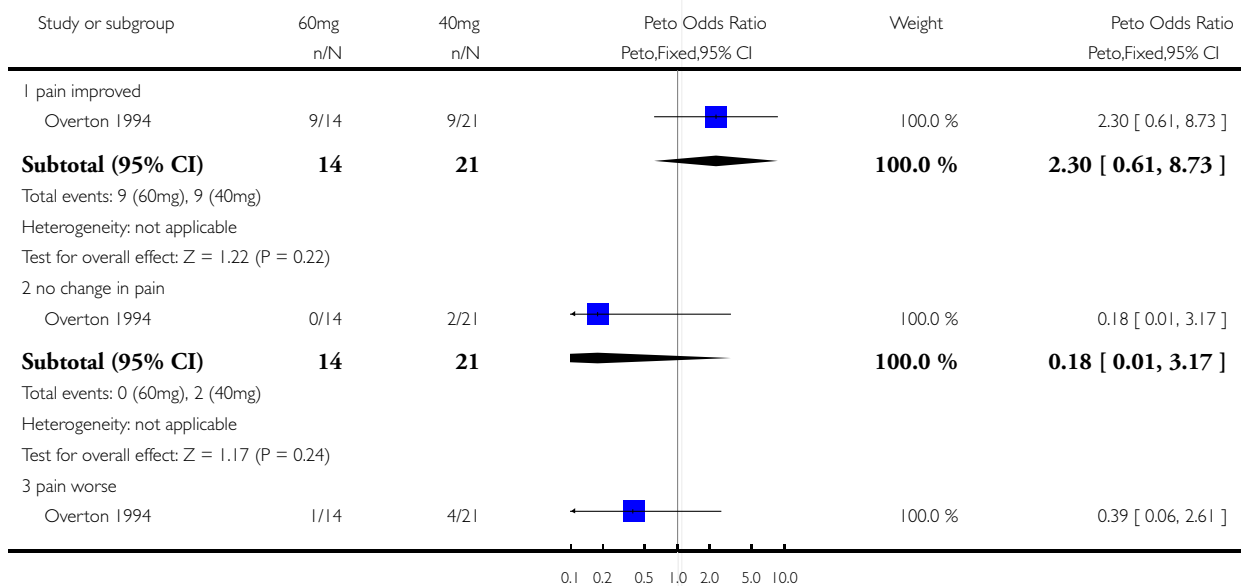


Analysis 3.2. Comparison 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG., Outcome 2 Subjective efficacy at end of follow-up (18 months).

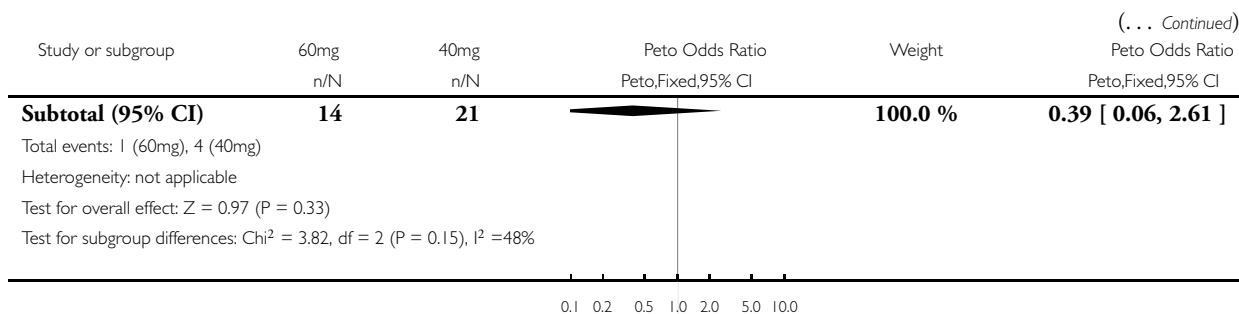
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

Outcome: 2 Subjective efficacy at end of follow-up (18 months)



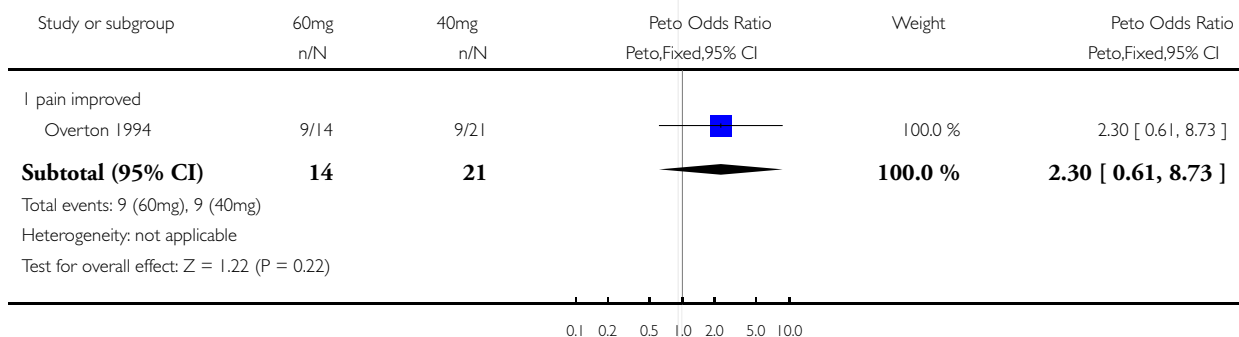
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

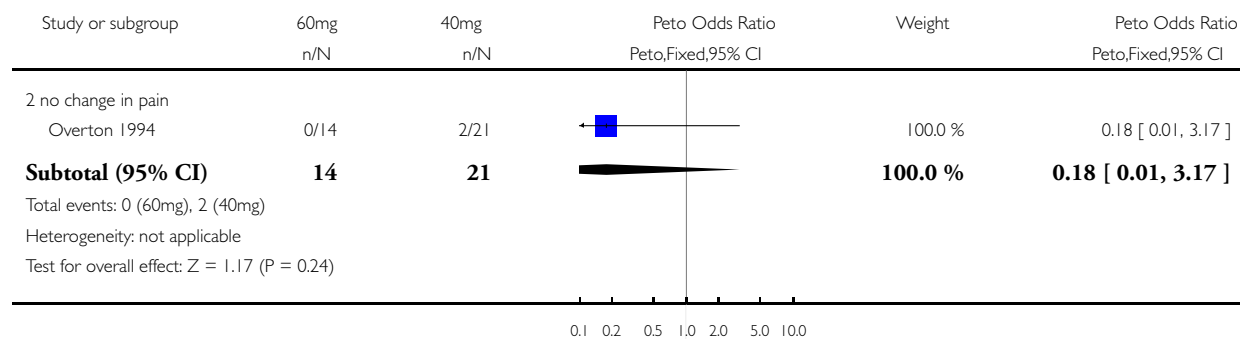
Outcome: 2 Subjective efficacy at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

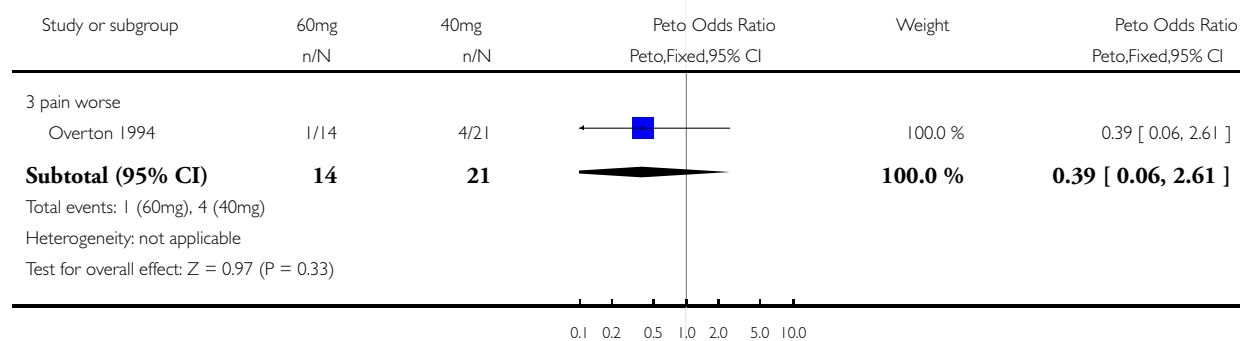
Outcome: 2 Subjective efficacy at end of follow-up (18 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

Outcome: 2 Subjective efficacy at end of follow-up (18 months)

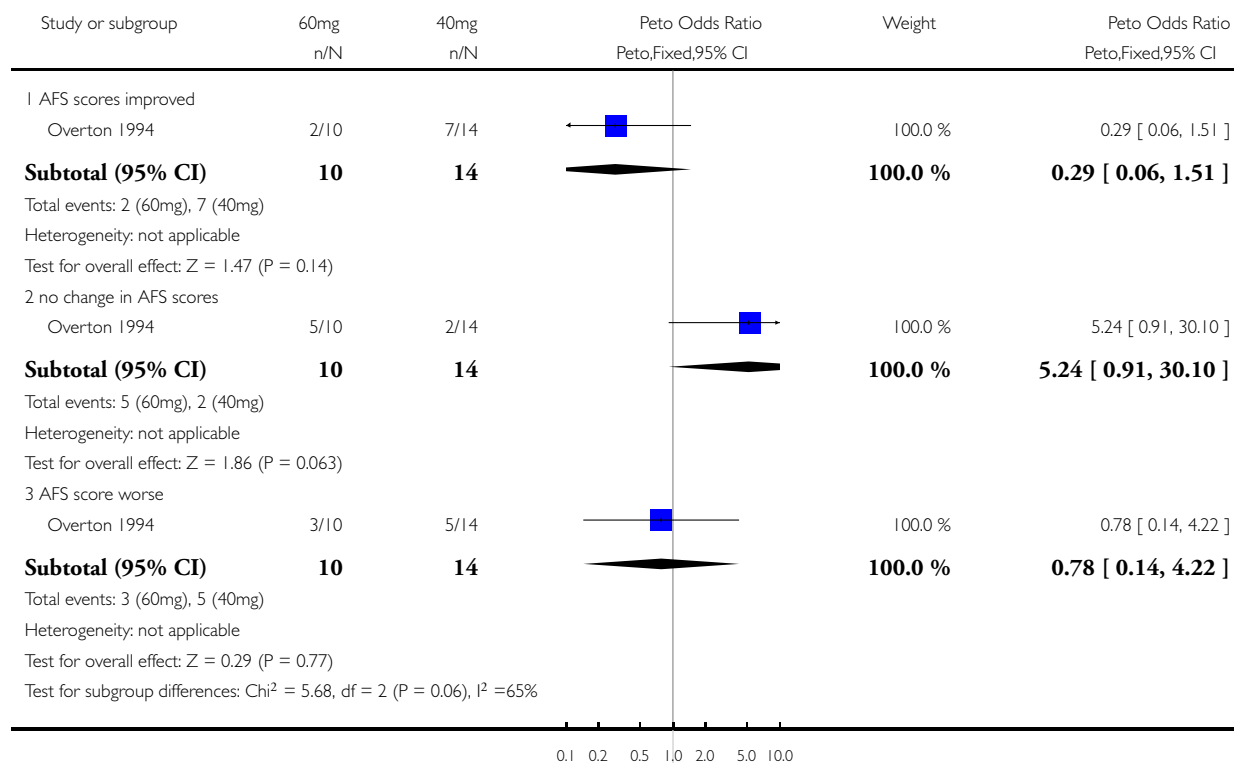


Analysis 3.3. Comparison 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG., Outcome 3 Objective efficacy at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

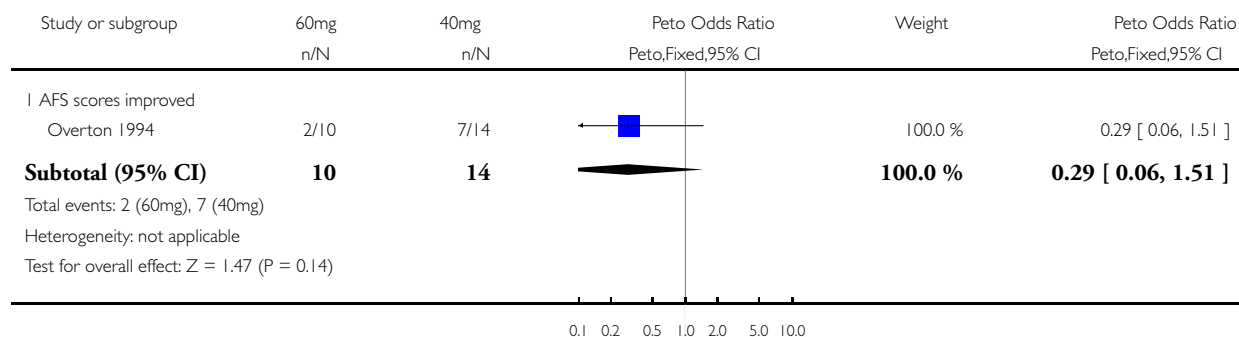
Outcome: 3 Objective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

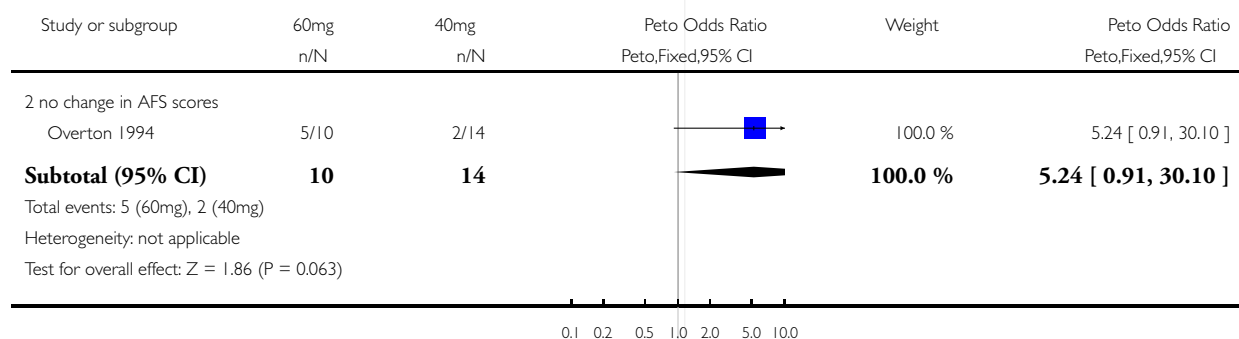
Outcome: 3 Objective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

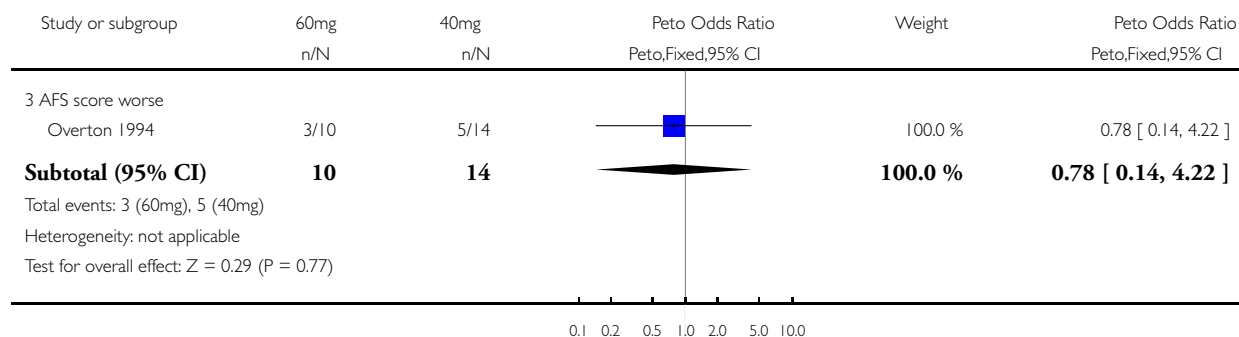
Outcome: 3 Objective efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 3 DYDROGESTERONE 60MG VS DYDROGESTERONE 40MG.

Outcome: 3 Objective efficacy at end of treatment (6 months)



Patient assessed efficacy during and at end of treatment (6 and 12 months)

painful periods, visual analogue scale			
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 7 (5-10) and 6.5 (5.1-8.2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-3) and 2 (0.5-3.3) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0.5 (0-1.5) respectively
painful periods, verbal rating scale			
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 2 (1-3) and 2 (1-3) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 1 (0-1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively
pain on intercourse, visual analogue scale			
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 4 (0-8) and 3.5 (0-8.1) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-2.7) and 0 (0-3.2) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0.5) respectively
pain on intercourse, verbal rating scale			

Patient assessed efficacy during and at end of treatment (6 and 12 months) (Continued)

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 1 (0-2) and 1 (0-2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively
non-menstrual pain, visual analogue scale			
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 4 (0-7.5) and 4.1 (1-7.3) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0.2 (0-3) and 0 (0-2) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-0.5) respectively
non-menstrual pain, verbal rating scale			
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 1 (0-2) and 1 (0-2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-0.1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively

painful periods, visual analogue scale

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 7 (5-10) and 6.5 (5.1-8.2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-3) and 2 (0.5-3.3) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0.5 (0-1.5) respectively
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painful periods, verbal rating scale

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 2 (1-3) and 2 (1-3) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 1 (0-1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively
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pain on intercourse, visual analogue scale

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 4 (0-8) and 3.5 (0-8.1) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-2.7) and 0 (0-3.2) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0.5) respectively
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pain on intercourse, verbal rating scale

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 1 (0-2) and 1 (0-2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively
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non-menstrual pain, visual analogue scale

Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 4 (0-7.5) and 4.1 (1-7.3) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0.2 (0-3) and 0 (0-2) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-0.5) respectively
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non-menstrual pain, verbal rating scale

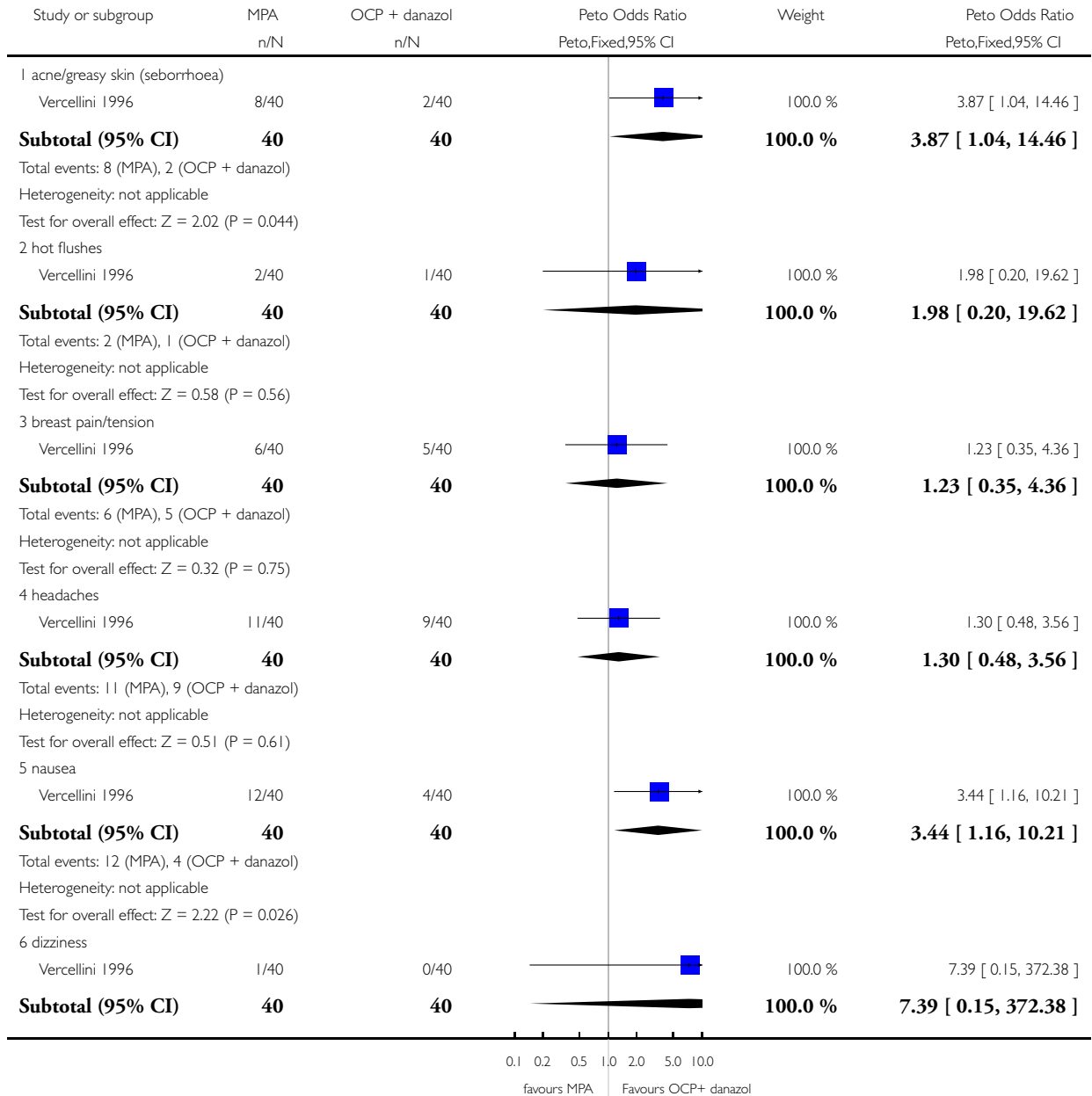
Vercellini 1996	Baseline values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 1 (0-2) and 1 (0-2) respectively	Month six values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-1) and 0 (0-0.1) respectively	Month twelve values (range) for depot medroxyprogesterone acetate and oral contraceptive plus danazol were 0 (0-0) and 0 (0-0) respectively
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Analysis 4.2. Comparison 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL, Outcome 2 Side effects.

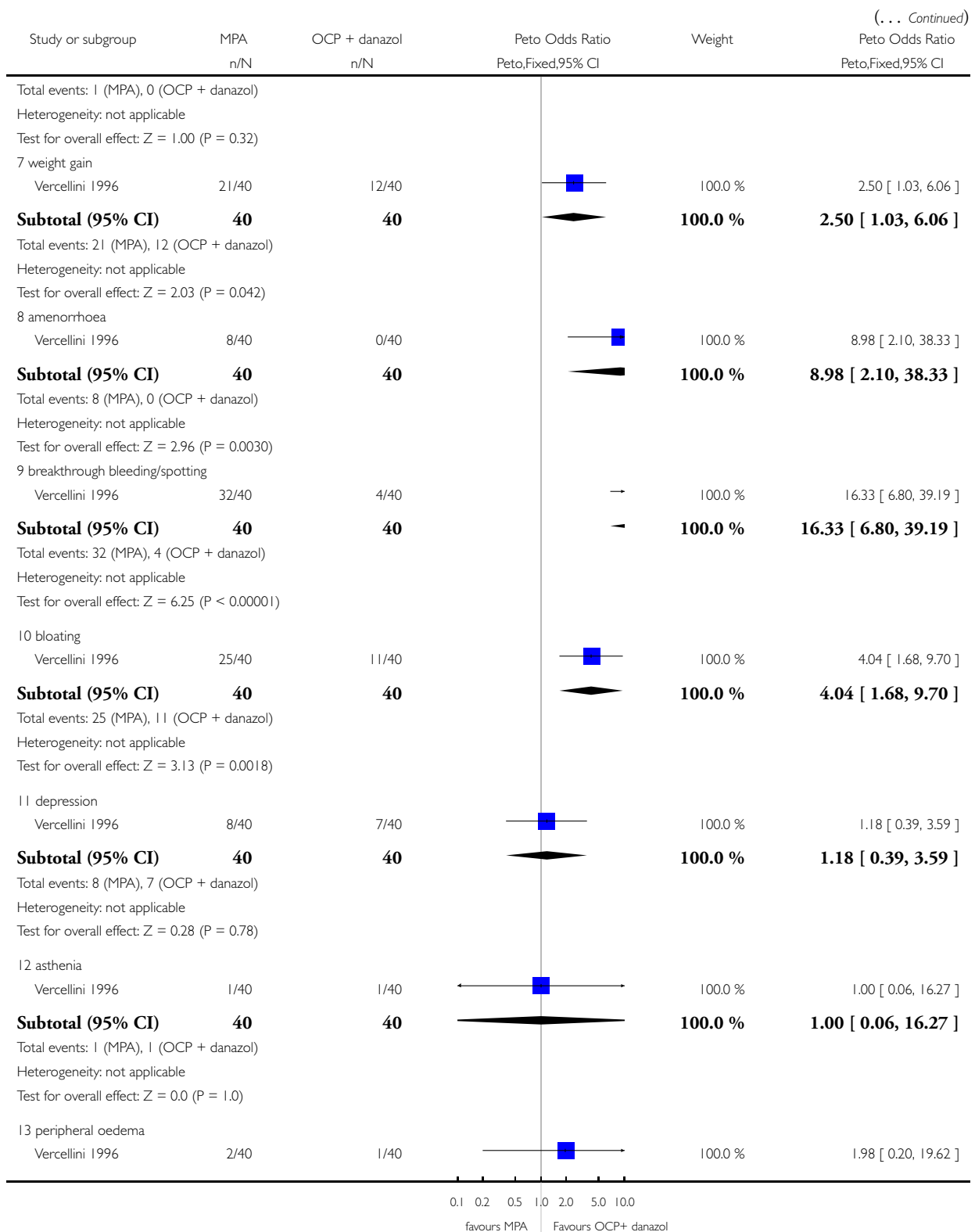
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

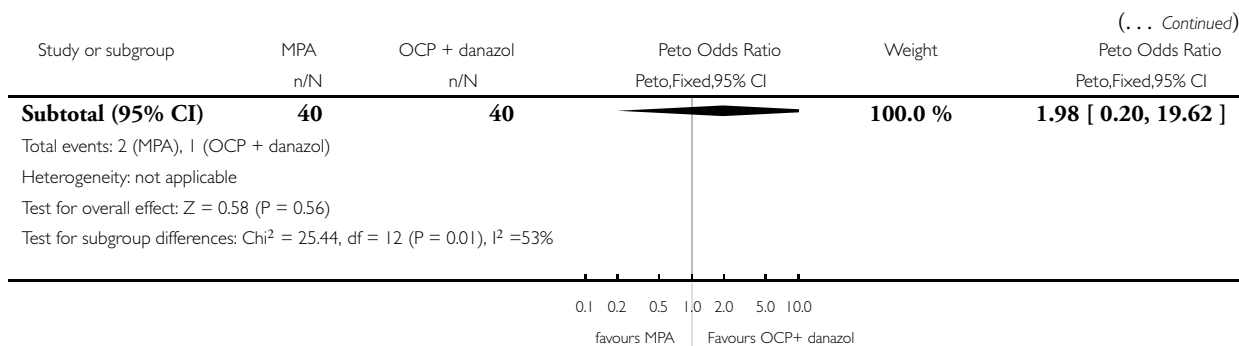
Outcome: 2 Side effects



(Continued ...)



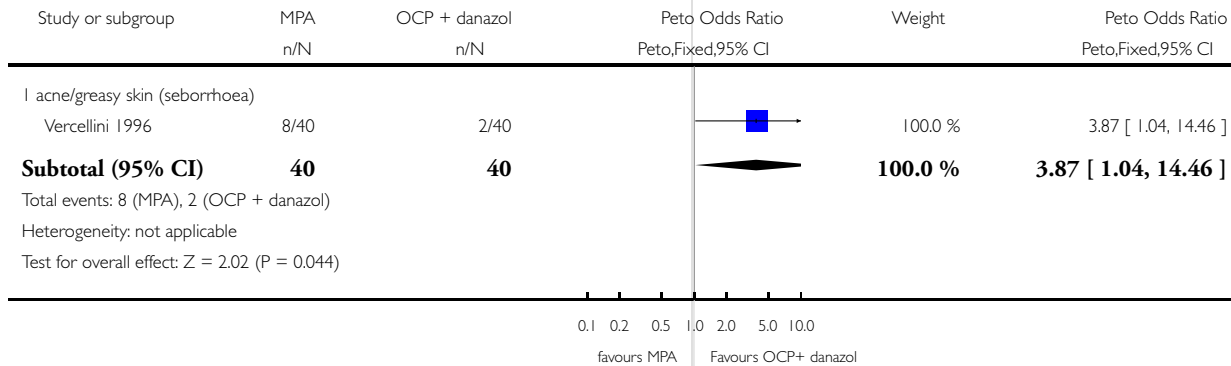
(Continued . . .)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

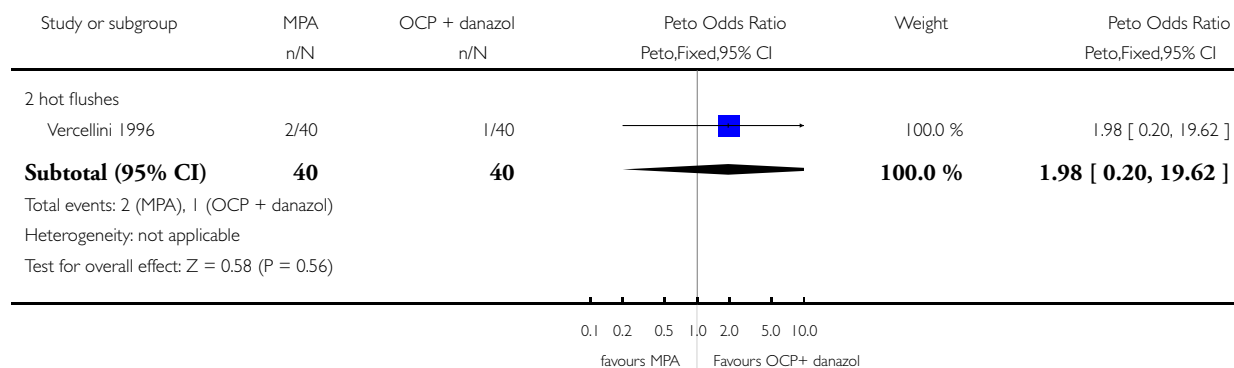
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

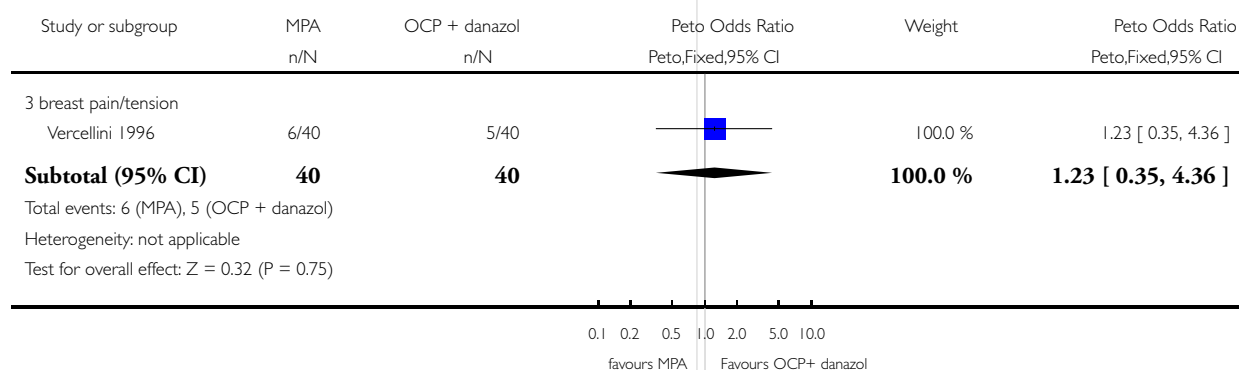
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

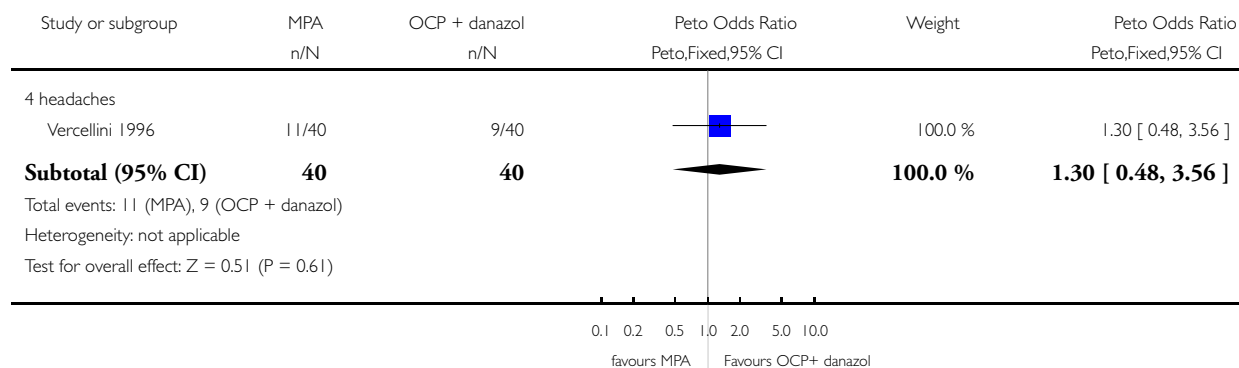
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

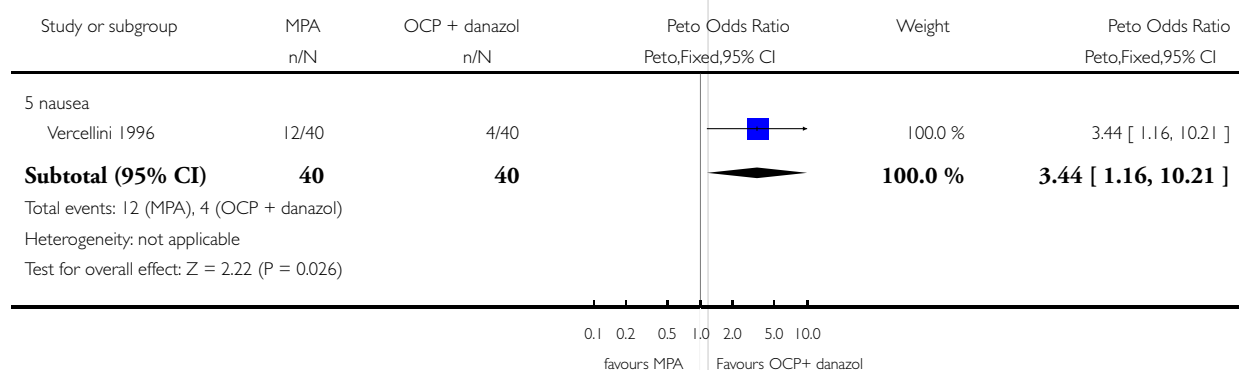
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

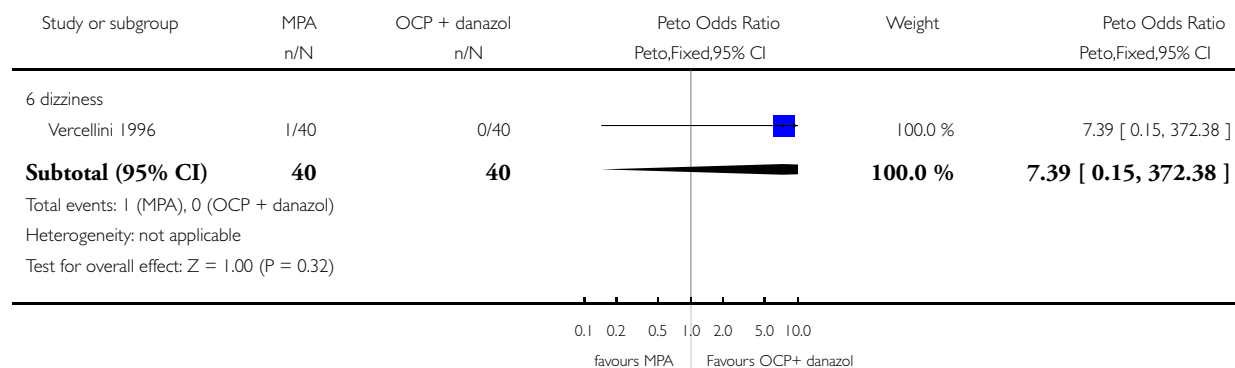
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

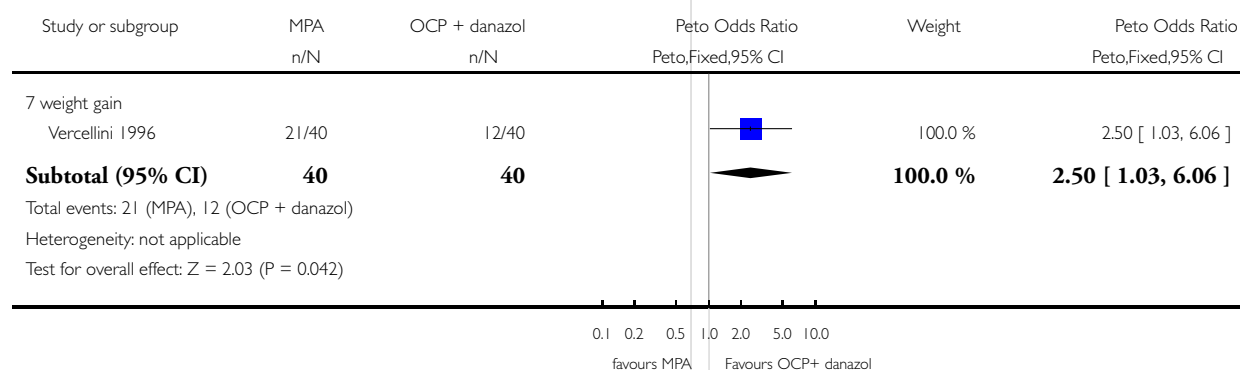
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

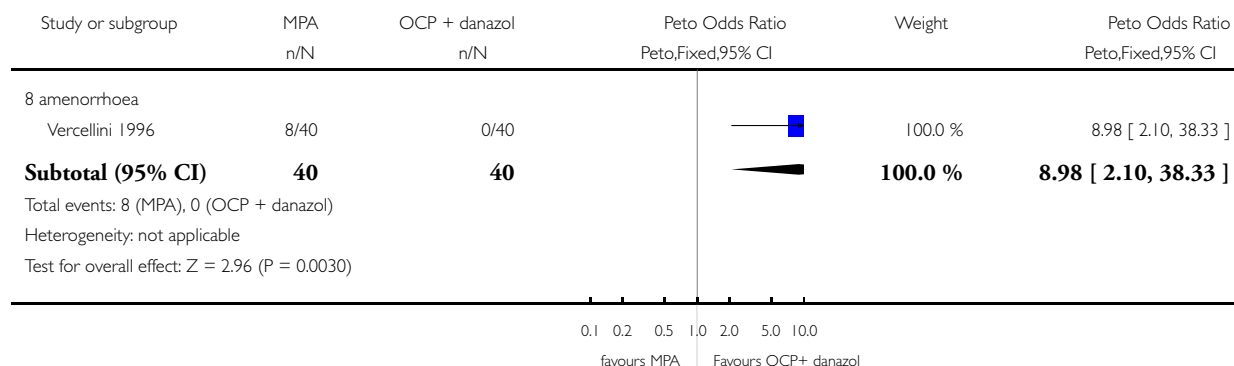
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

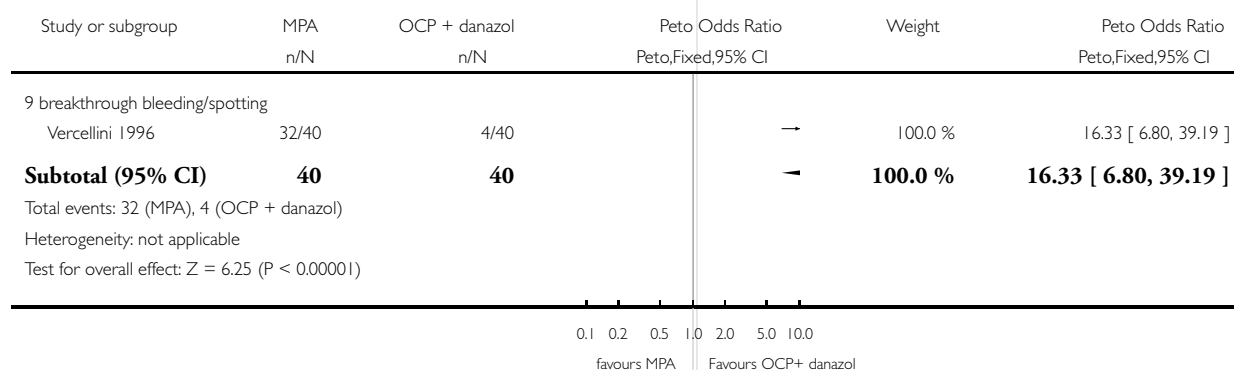
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

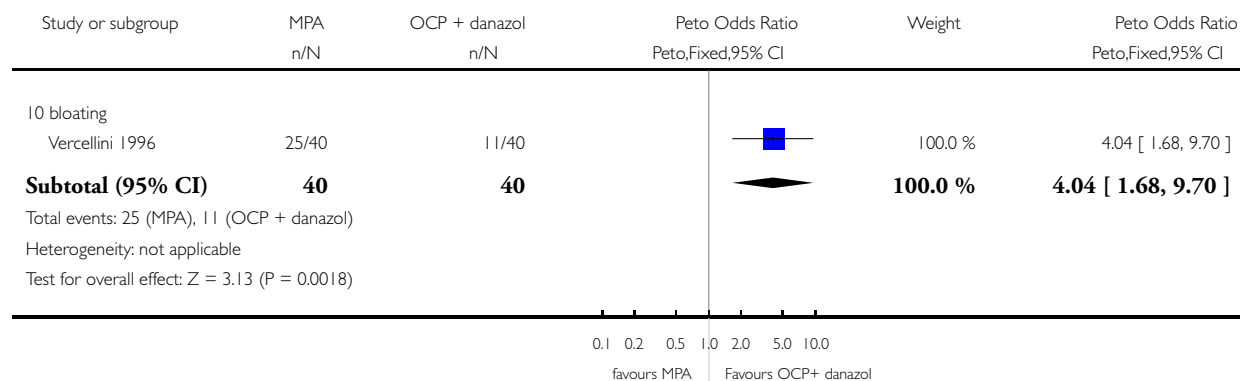
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

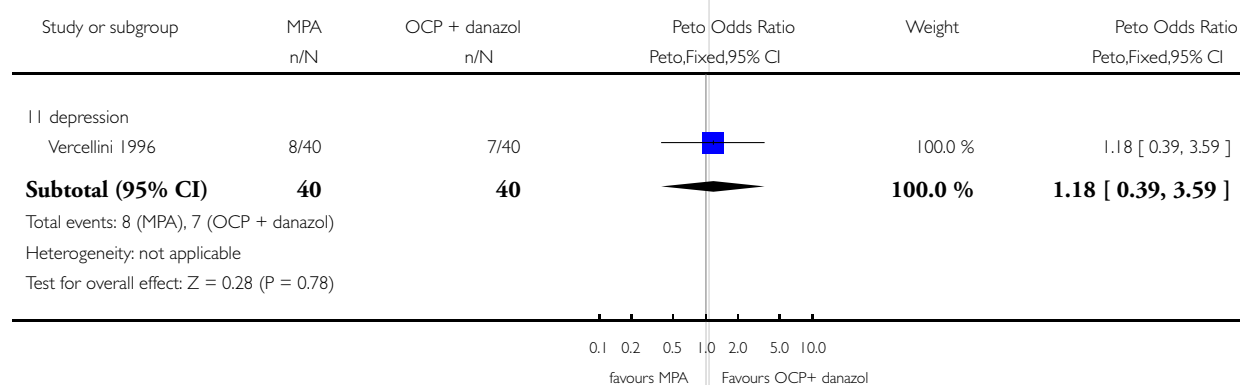
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

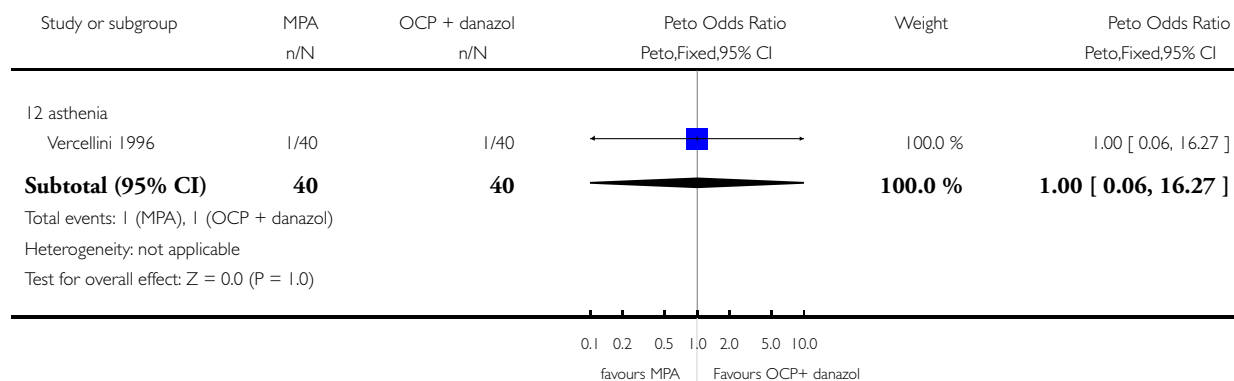
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

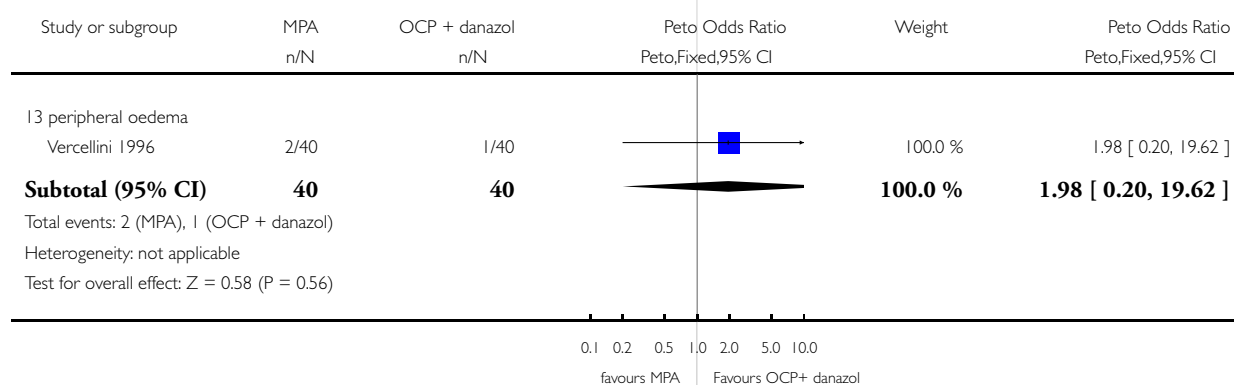
Outcome: 2 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 4 MEDROXYPROGESTERONE ACETATE VS ORAL CONTRACEPTIVE PILL PLUS LOW DOSE DANAZOL

Outcome: 2 Side effects

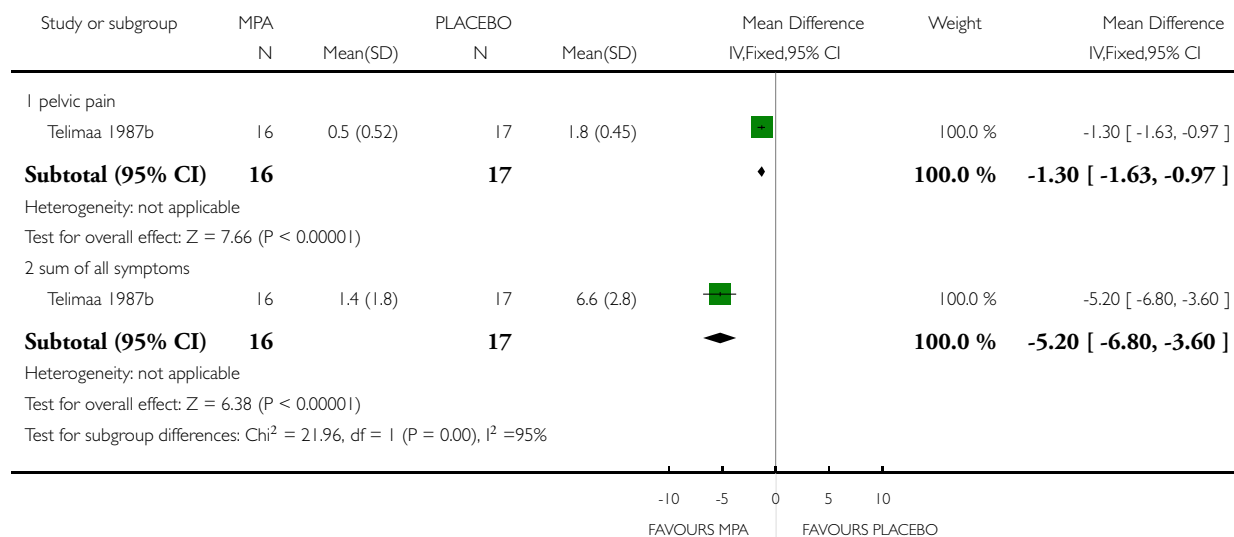


Analysis 5.1. Comparison 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO, Outcome 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

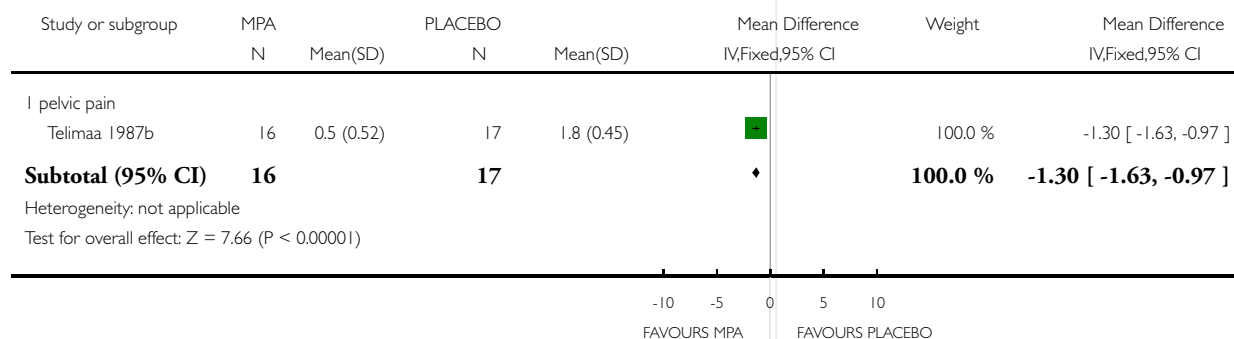
Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

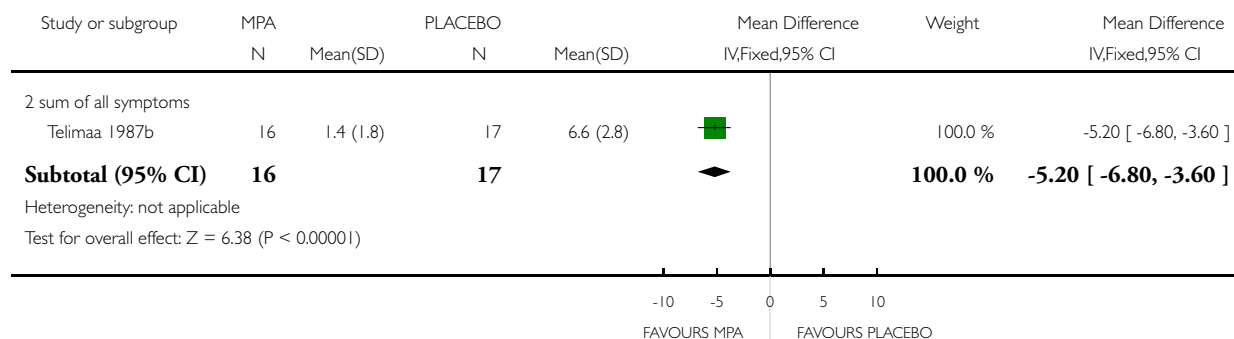
Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)

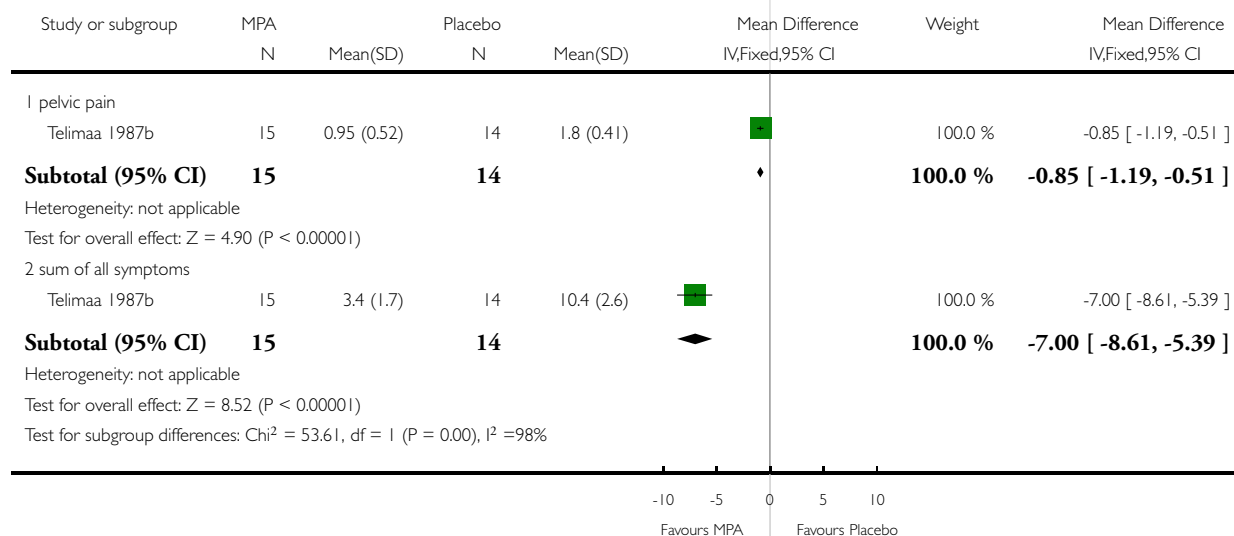


Analysis 5.2. Comparison 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO, Outcome 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

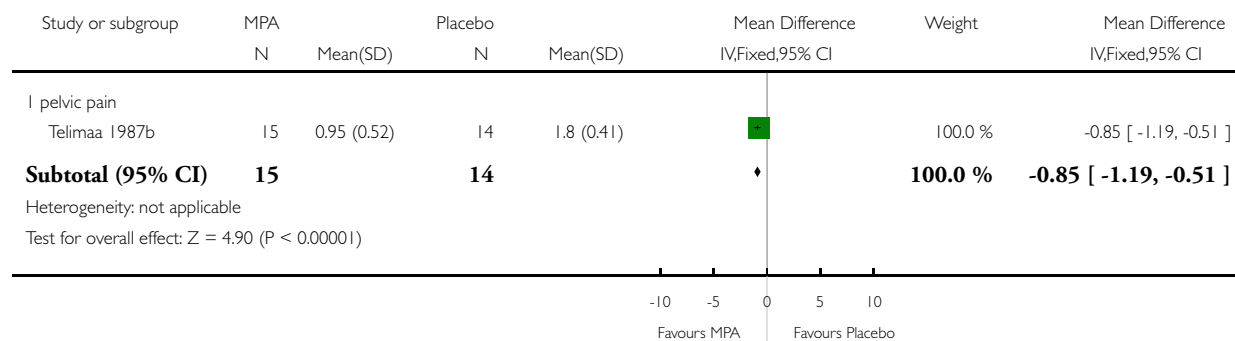
Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

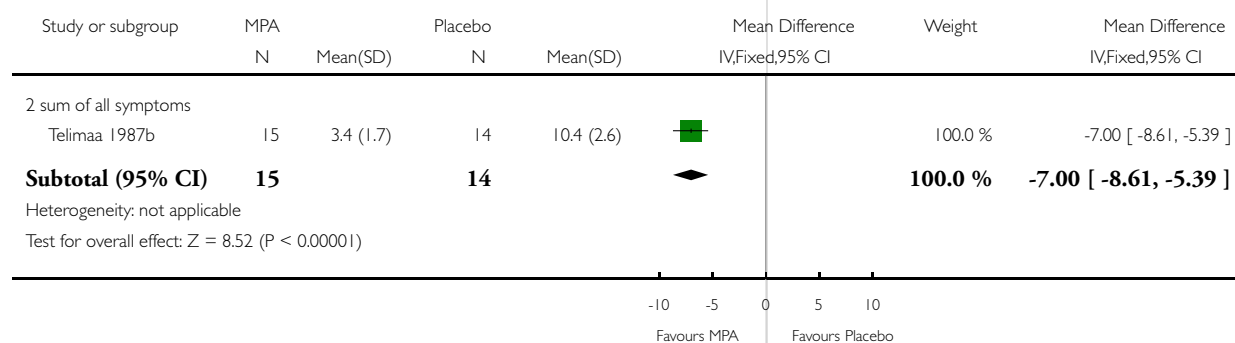
Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)

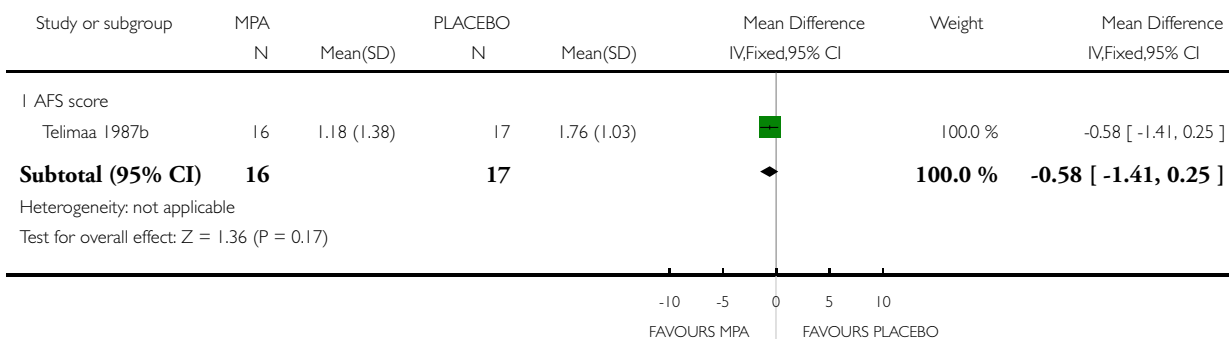


Analysis 5.3. Comparison 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO, Outcome 3 Objective efficacy at end of follow up (12 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

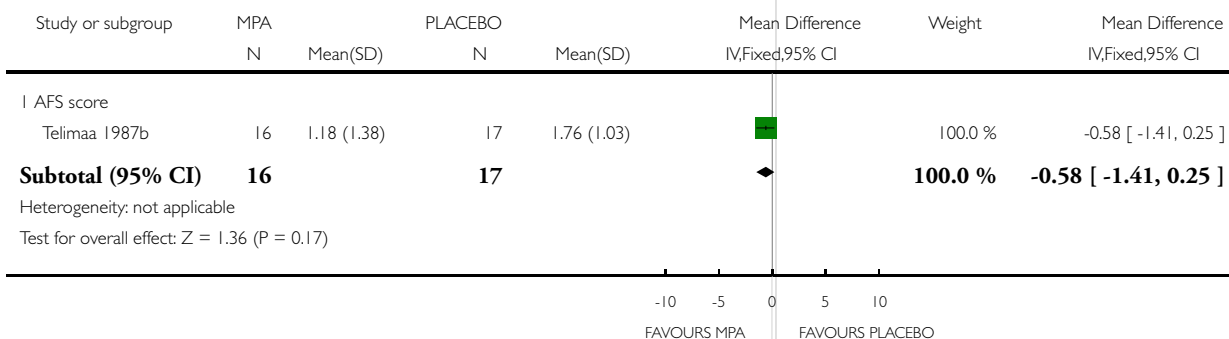
Outcome: 3 Objective efficacy at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

Outcome: 3 Objective efficacy at end of follow up (12 months)

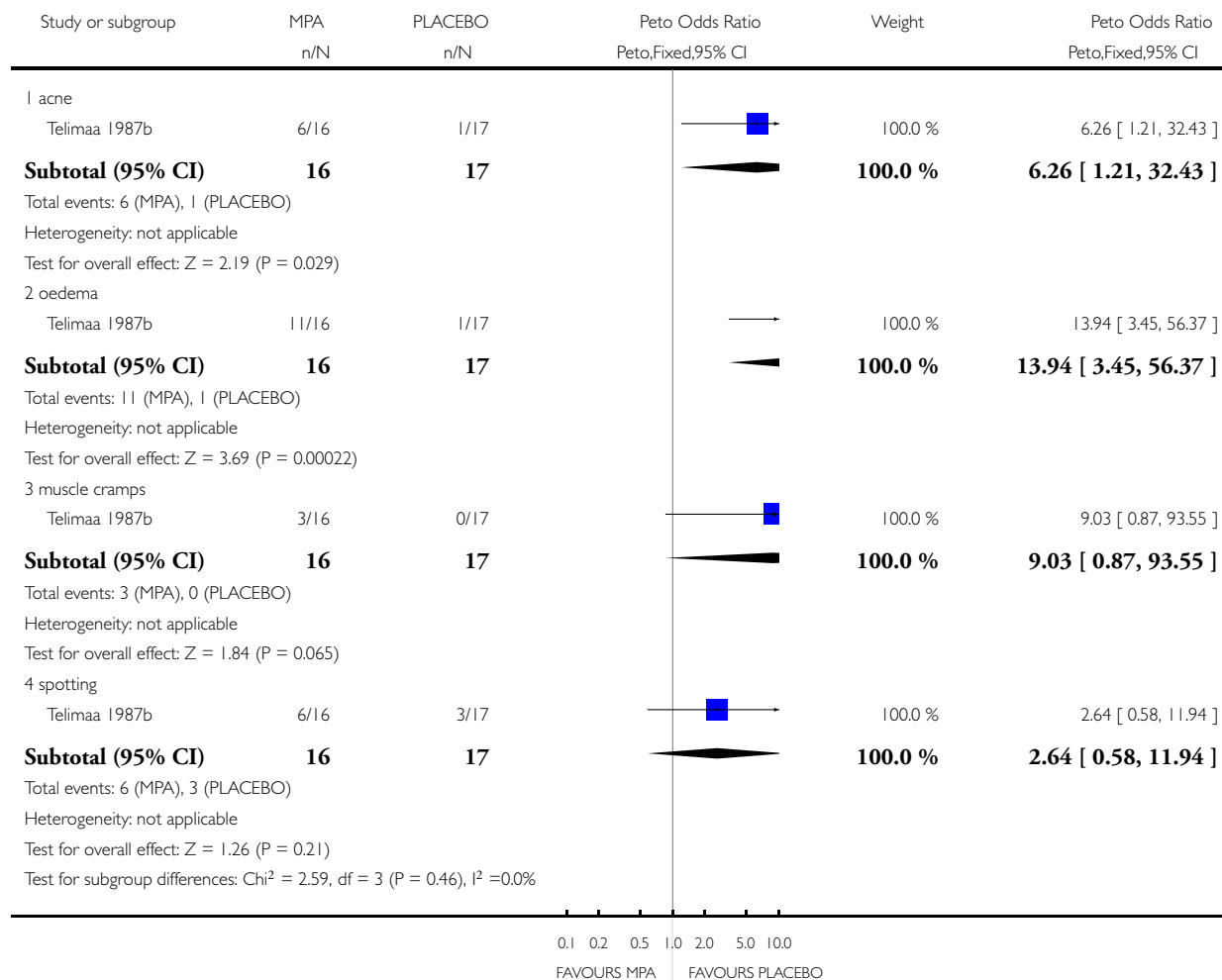


Analysis 5.4. Comparison 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO, Outcome 4 Side effects.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

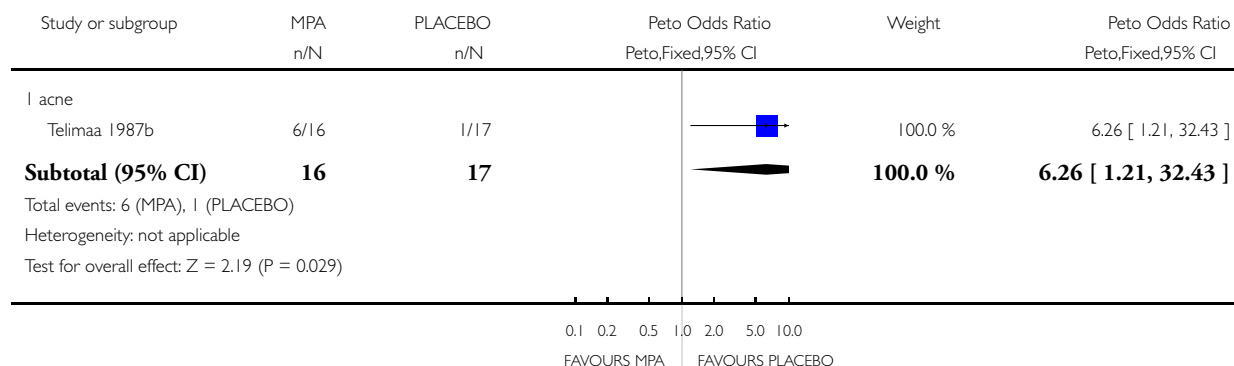
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

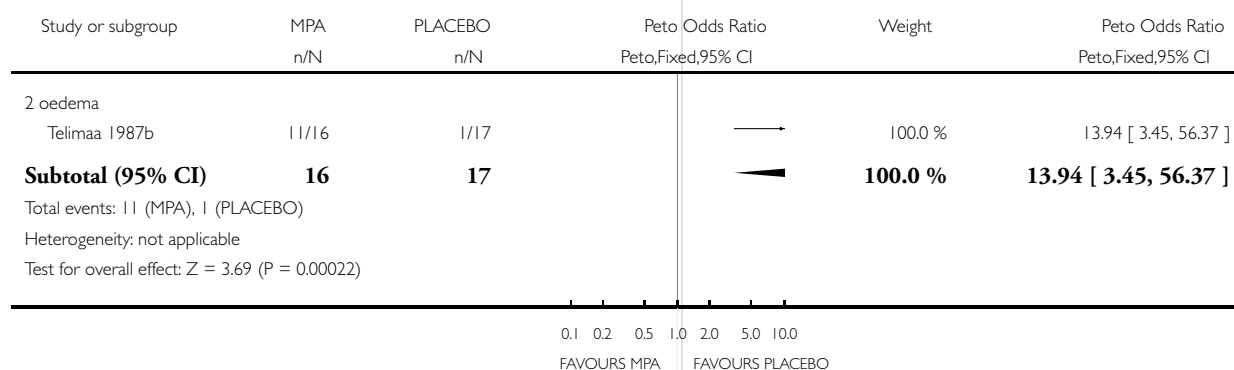
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

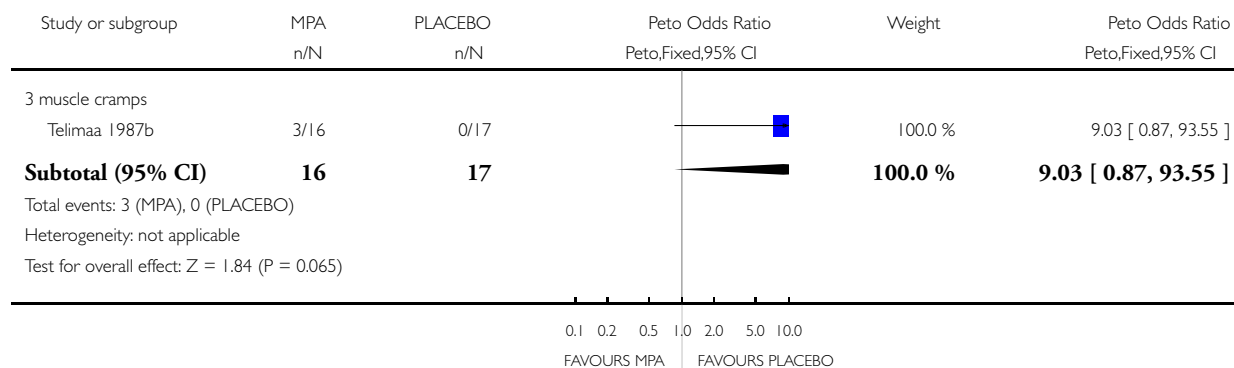
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

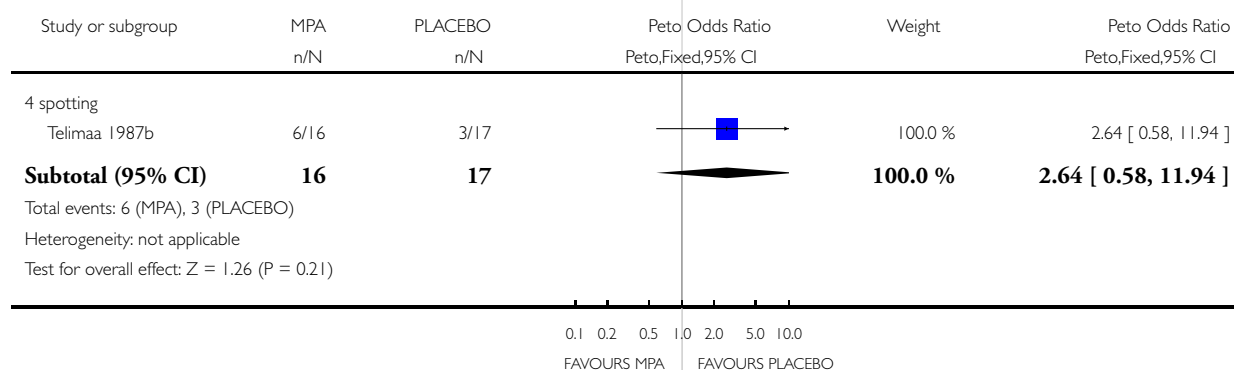
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 5 MEDROXYPROGESTERONE ACETATE VS PLACEBO

Outcome: 4 Side effects

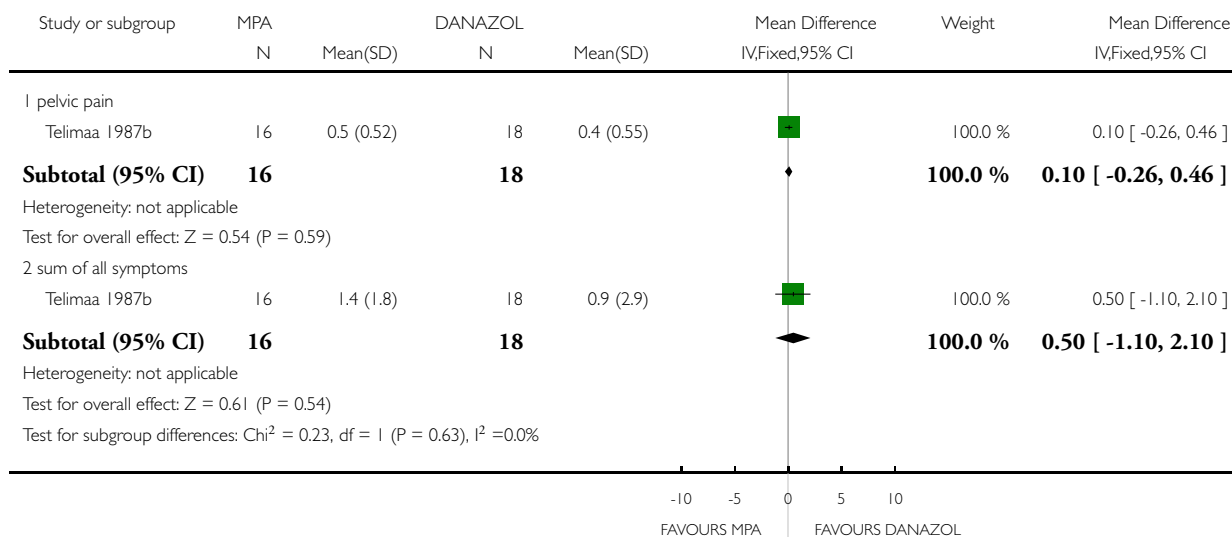


Analysis 6.1. Comparison 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL, Outcome 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

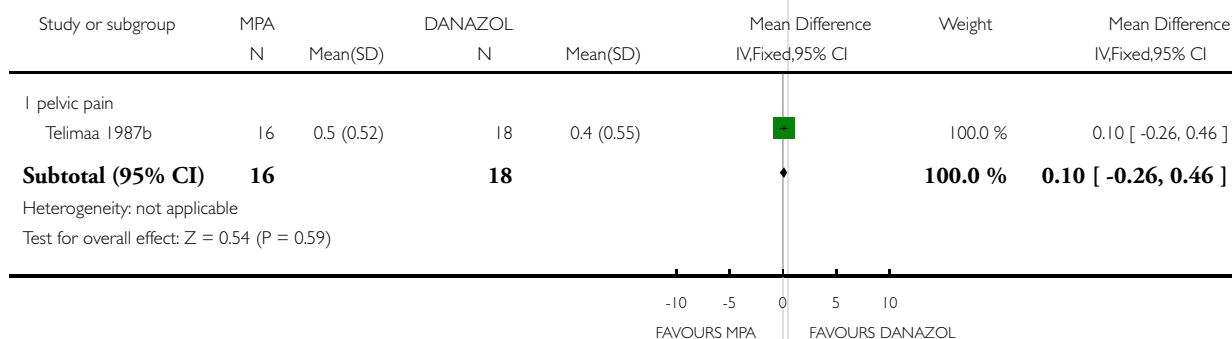
Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

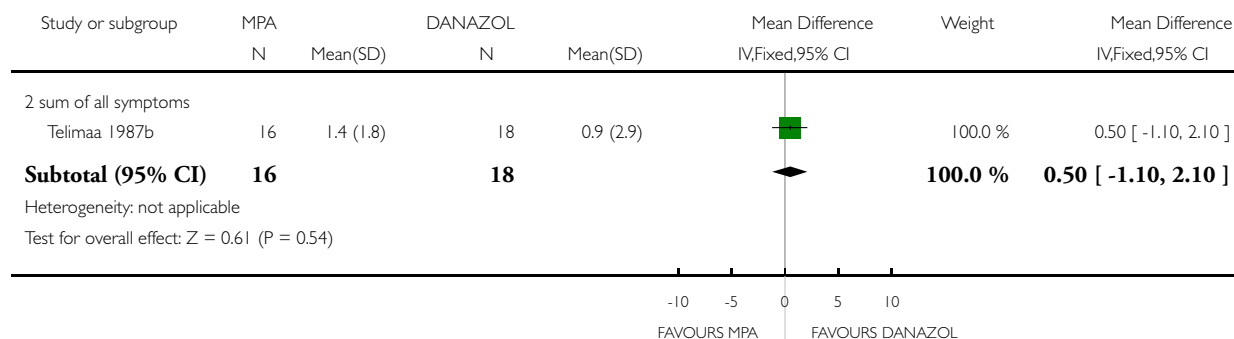
Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

Outcome: 1 Patient assessed efficacy, 4 point verbal rating scale at end of treatment (6 months)

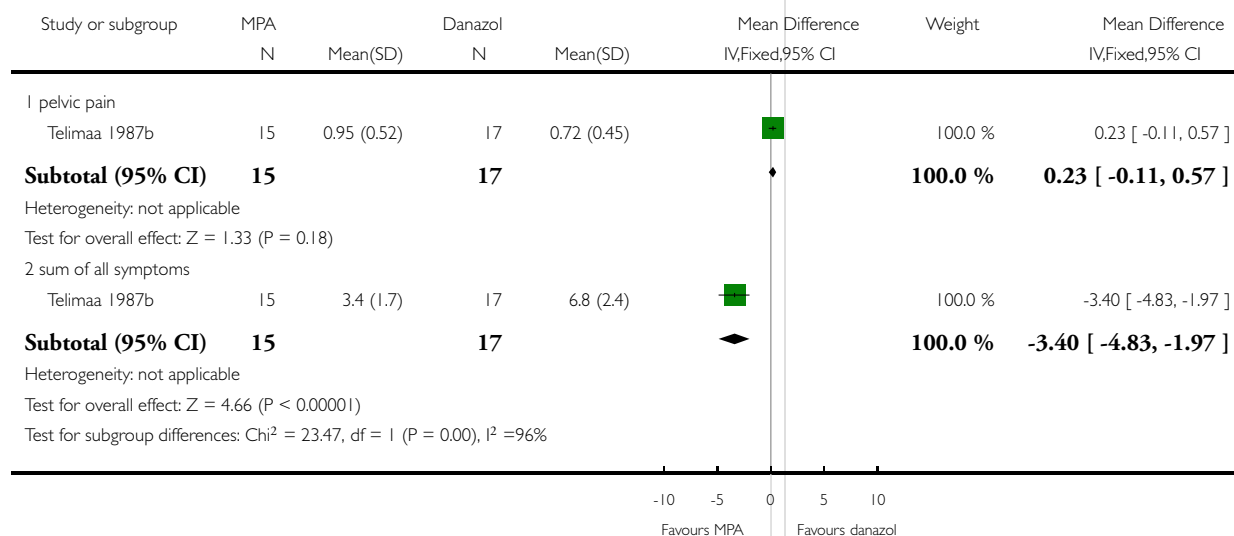


Analysis 6.2. Comparison 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL, Outcome 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

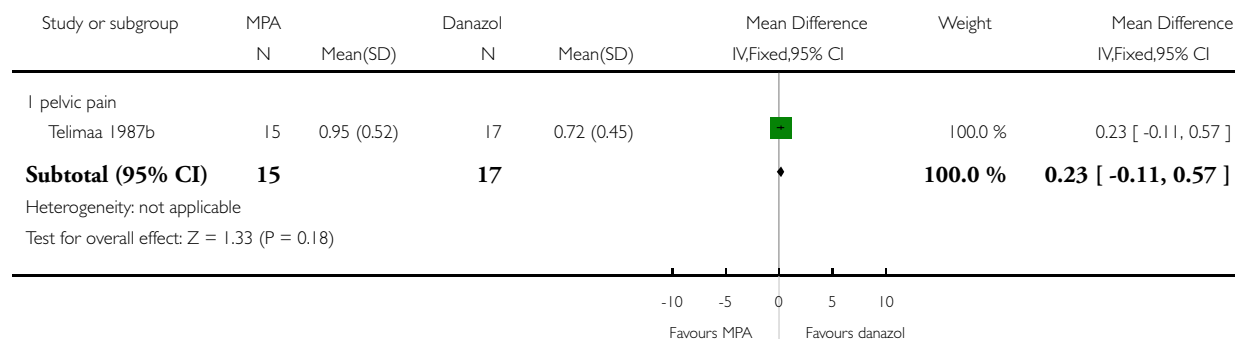
Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

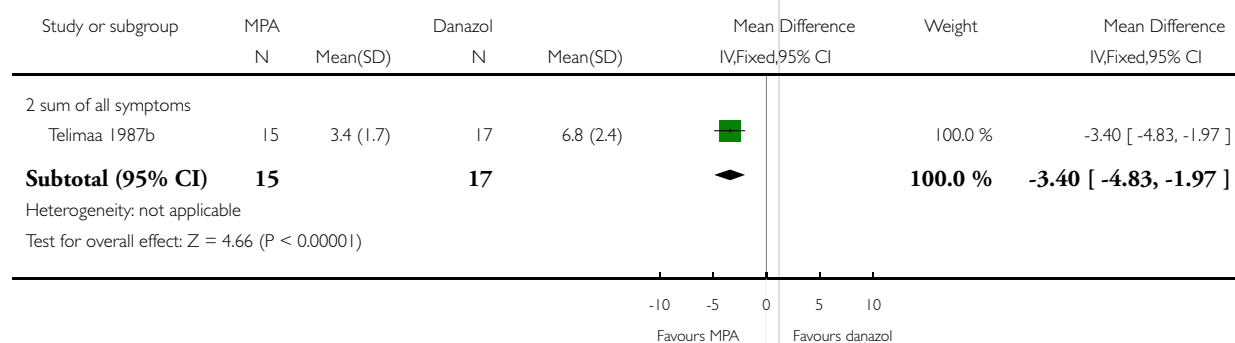
Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

Outcome: 2 Patient assessed efficacy, 4 point verbal rating scale at end of follow up (12 months)

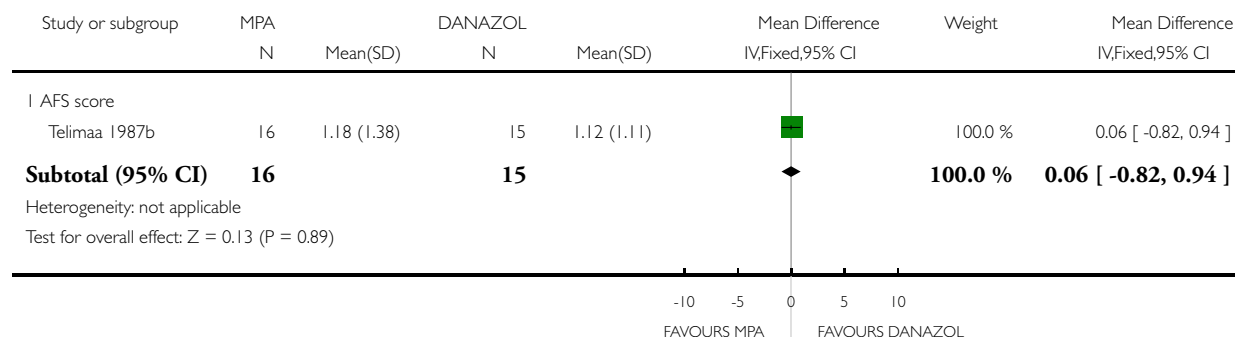


Analysis 6.3. Comparison 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL, Outcome 3 Objective efficacy at end of follow up (12 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

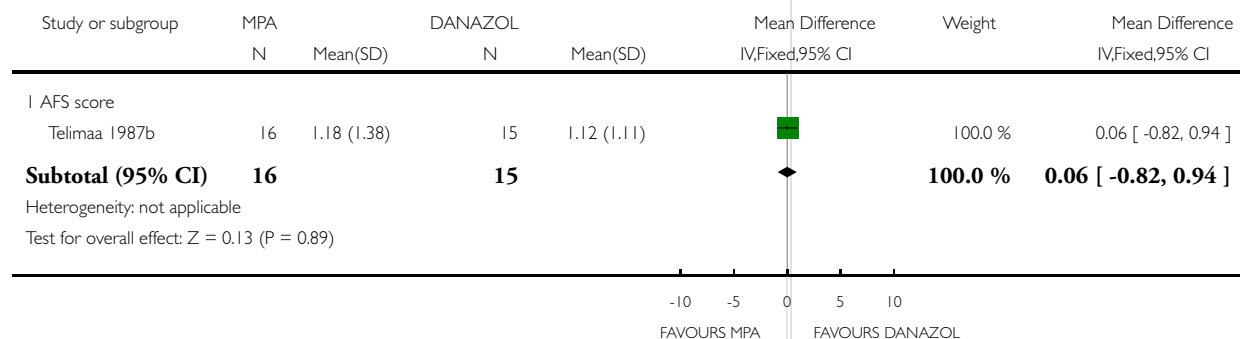
Outcome: 3 Objective efficacy at end of follow up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

Outcome: 3 Objective efficacy at end of follow up (12 months)

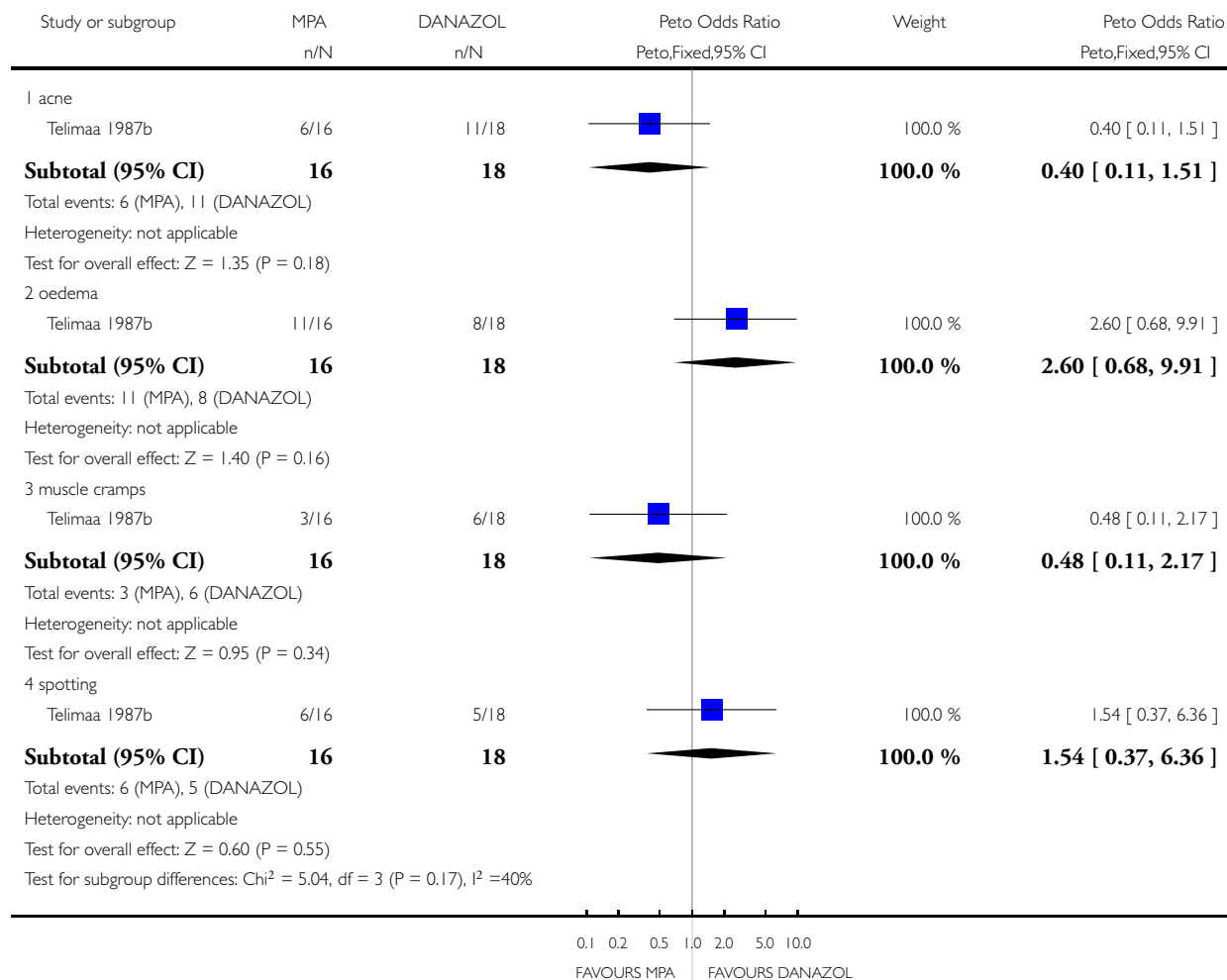


Analysis 6.4. Comparison 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL, Outcome 4 Side effects.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

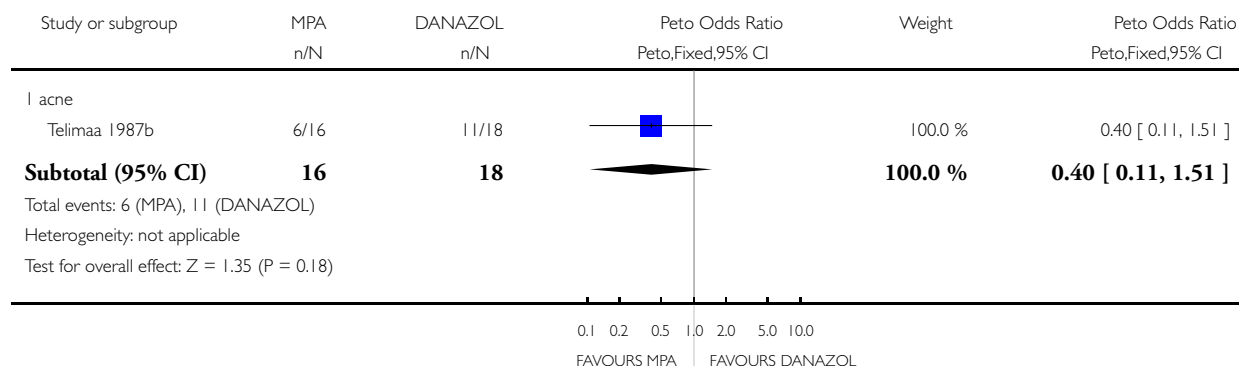
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

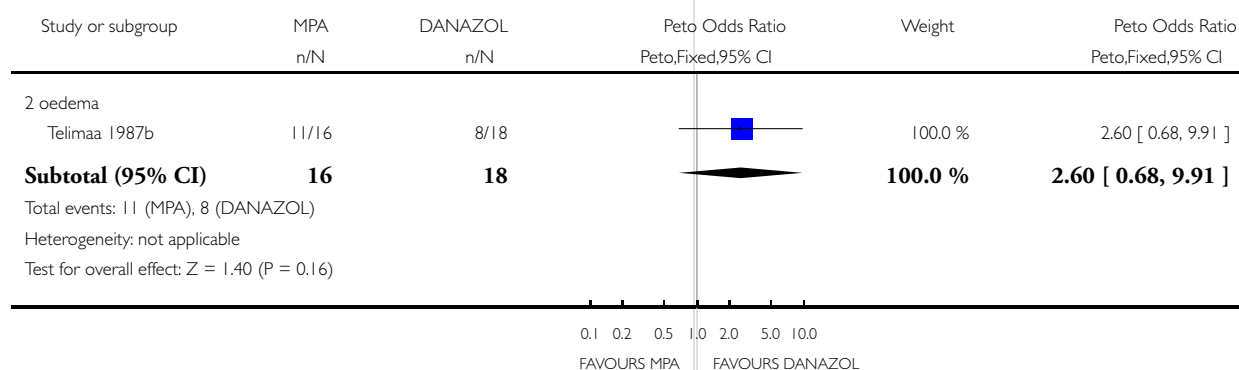
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

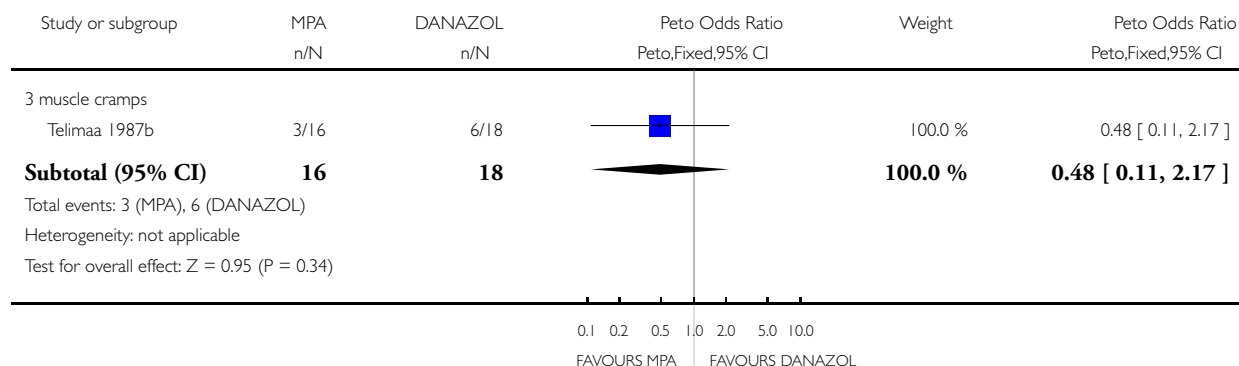
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

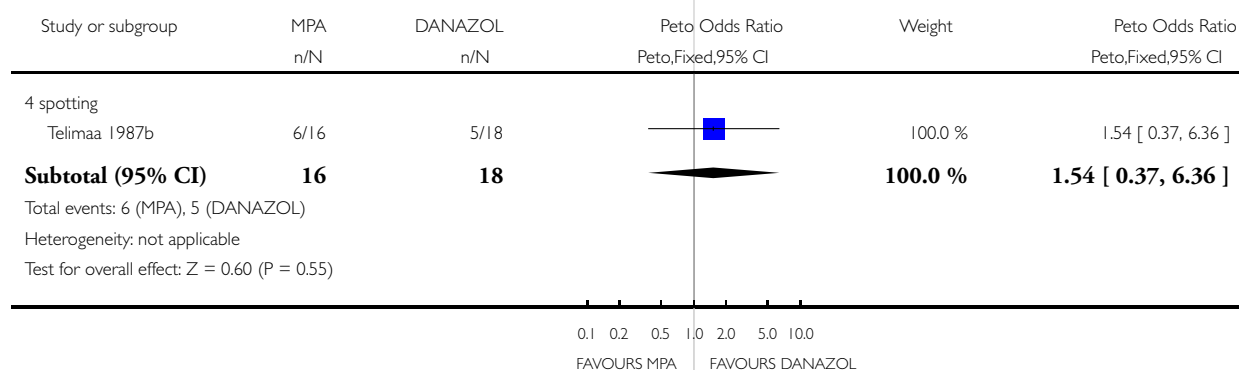
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 6 MEDROXYPROGESTERONE ACETATE VS DANAZOL

Outcome: 4 Side effects

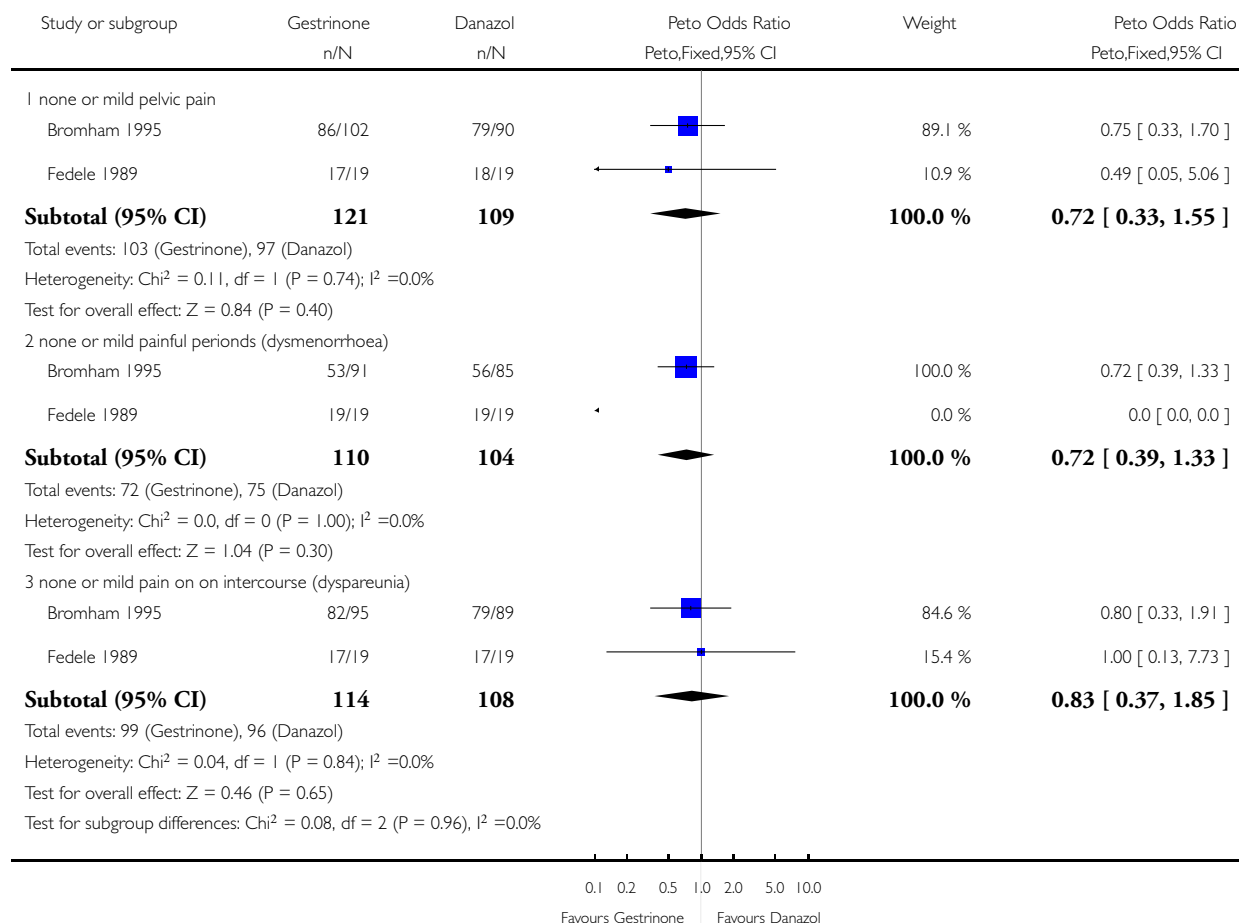


Analysis 10.1. Comparison 10 GESTRINONE VS DANAZOL, Outcome 1 Patient assessed efficacy at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

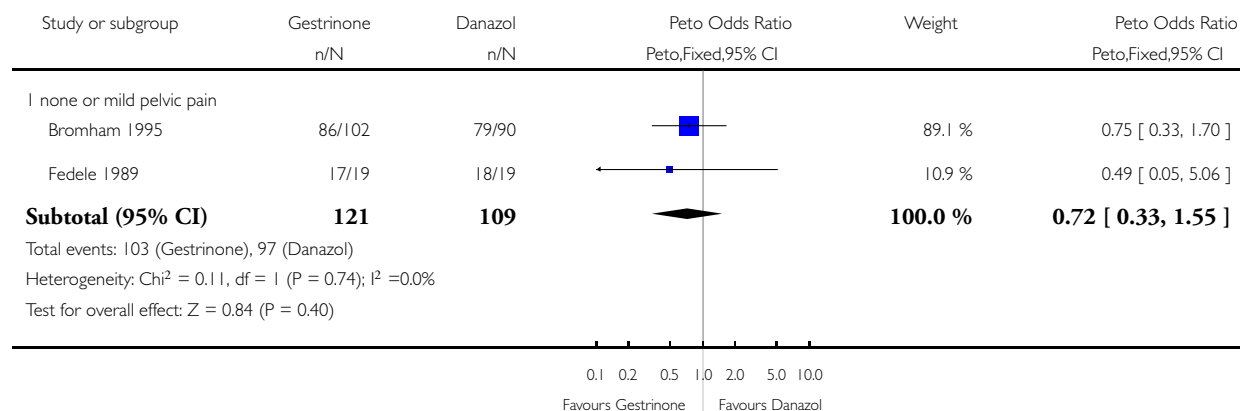
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

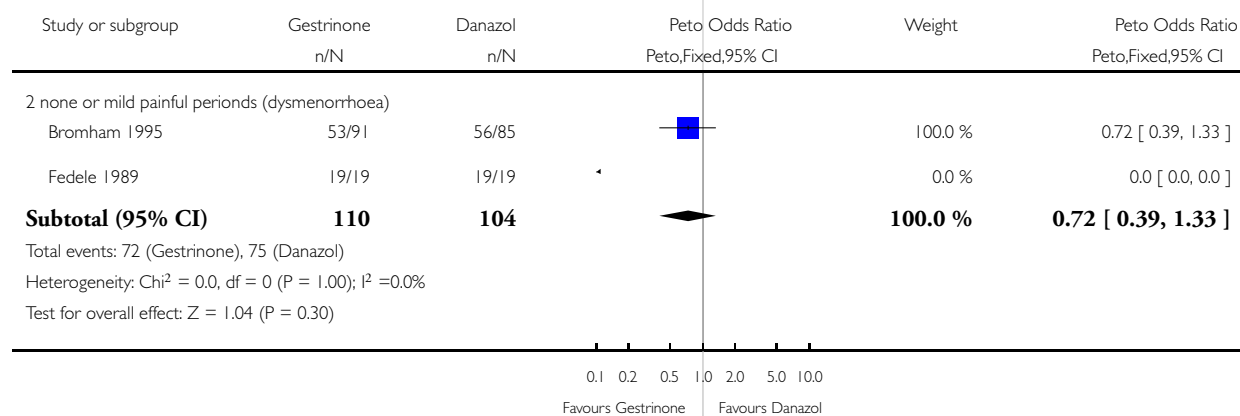
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

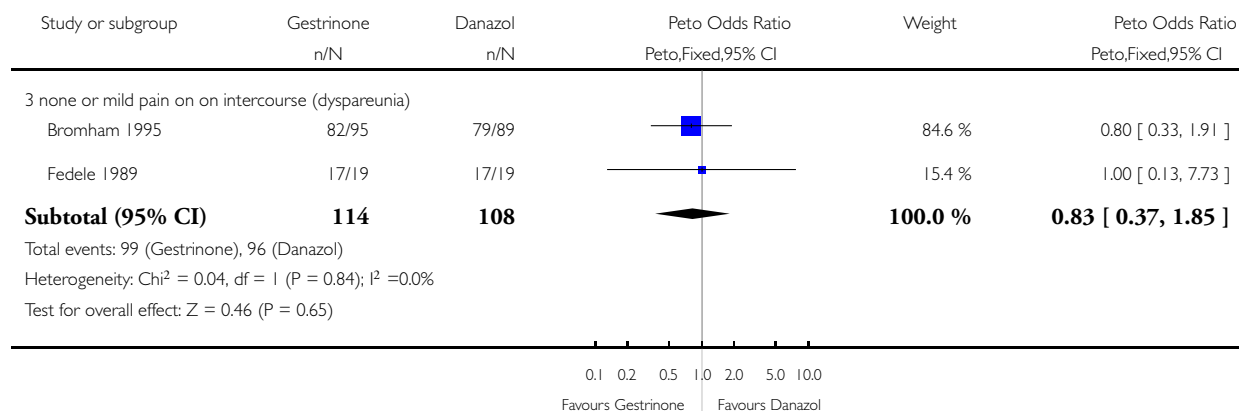
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

Outcome: 1 Patient assessed efficacy at end of treatment (6 months)

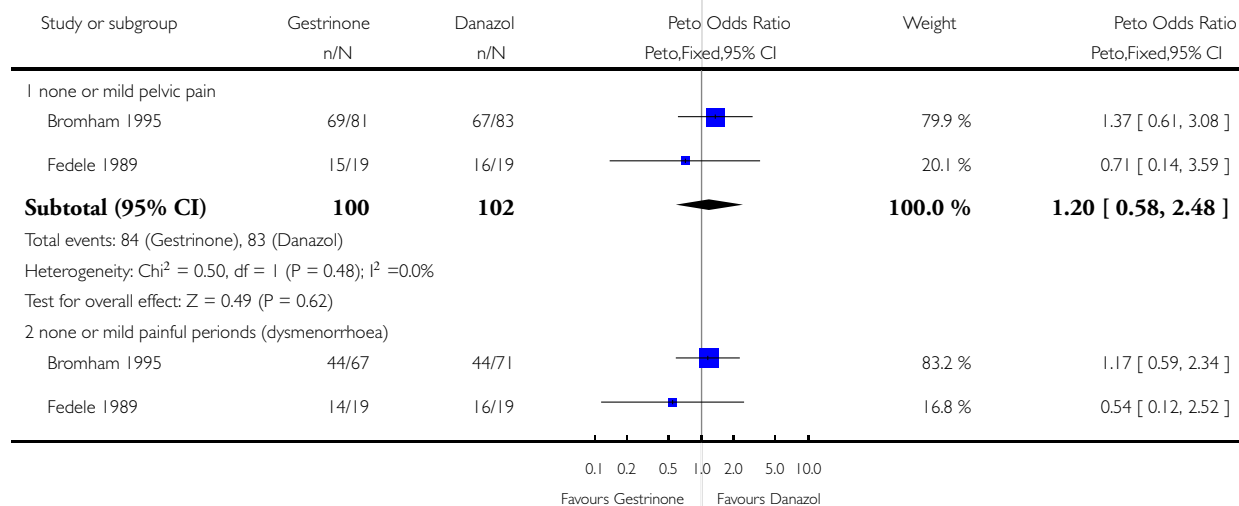


Analysis 10.2. Comparison 10 GESTRINONE VS DANAZOL, Outcome 2 Patient assessed efficacy 6 months after the end of treatment..

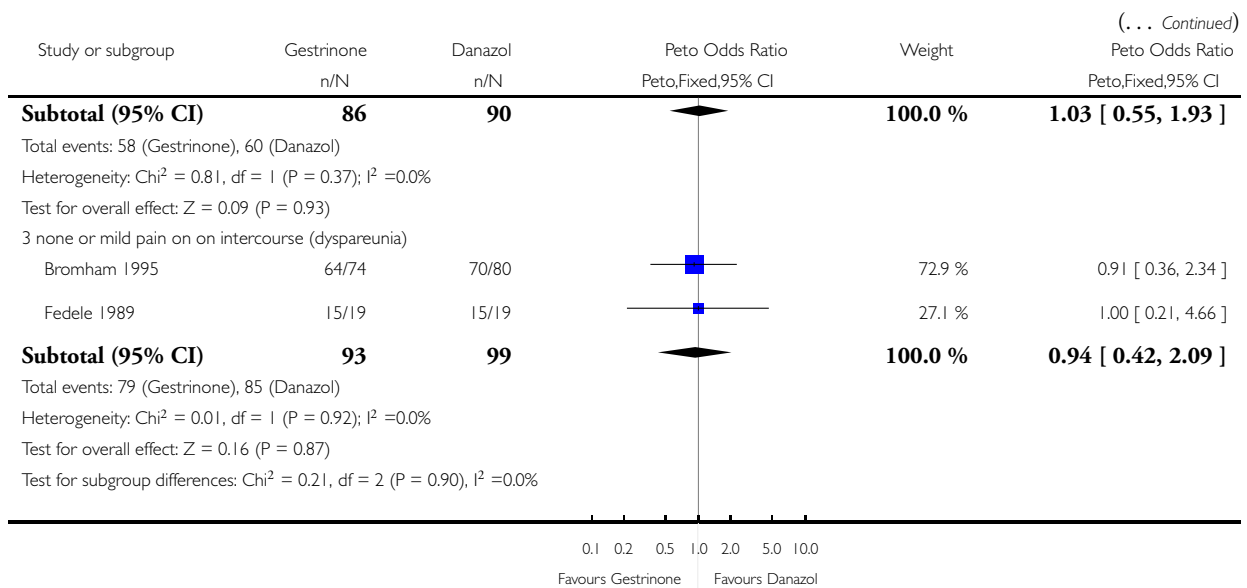
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

Outcome: 2 Patient assessed efficacy 6 months after the end of treatment.



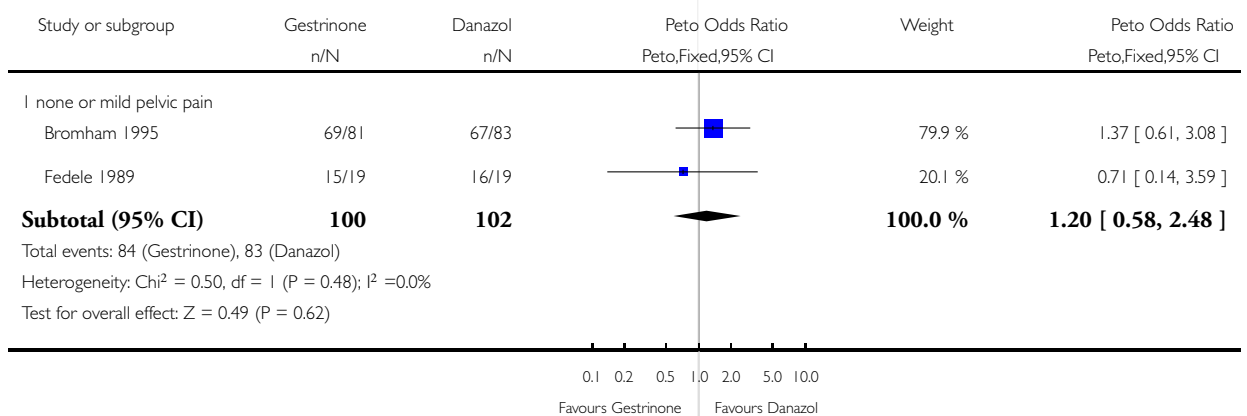
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

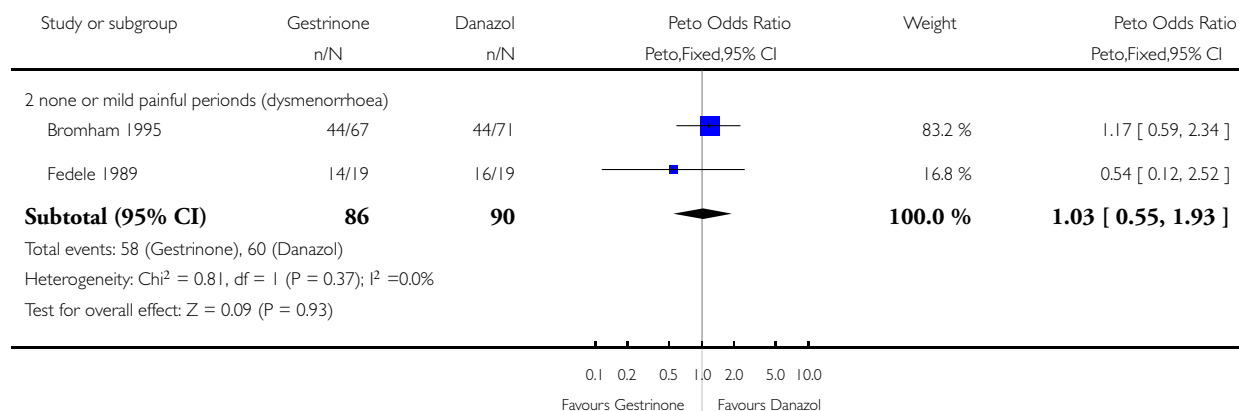
Outcome: 2 Patient assessed efficacy 6 months after the end of treatment.



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

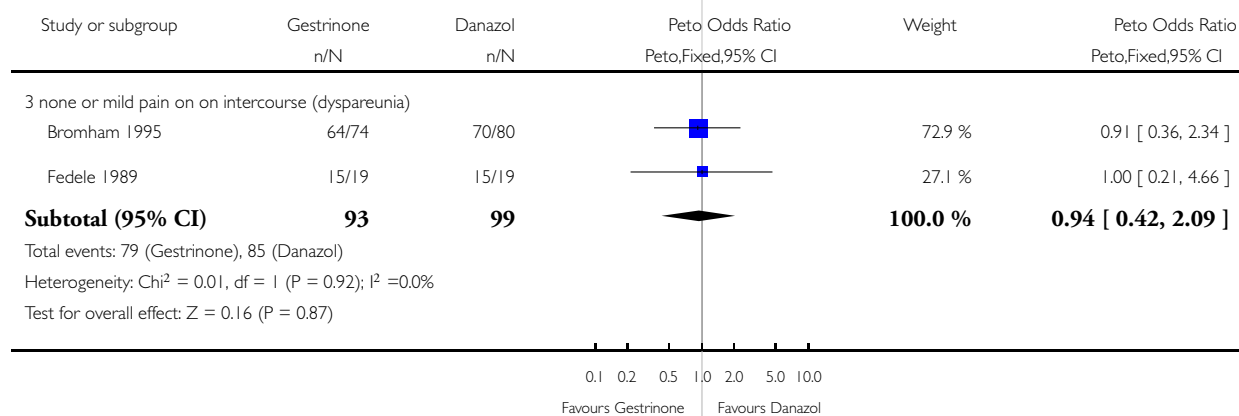
Outcome: 2 Patient assessed efficacy 6 months after the end of treatment.



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

Outcome: 2 Patient assessed efficacy 6 months after the end of treatment.

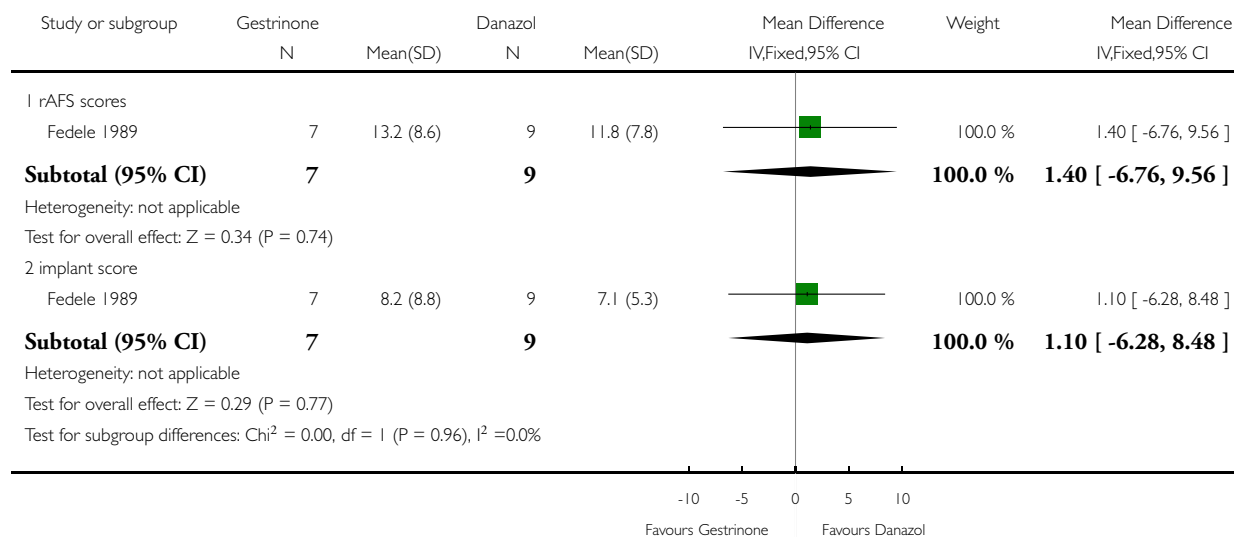


Analysis 10.3. Comparison 10 GESTRINONE VS DANAZOL, Outcome 3 Objective assessment of efficacy at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

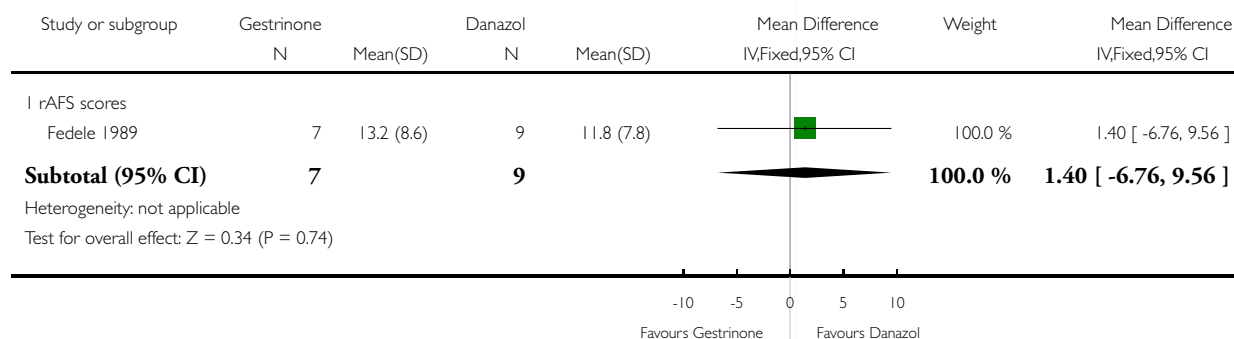
Outcome: 3 Objective assessment of efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

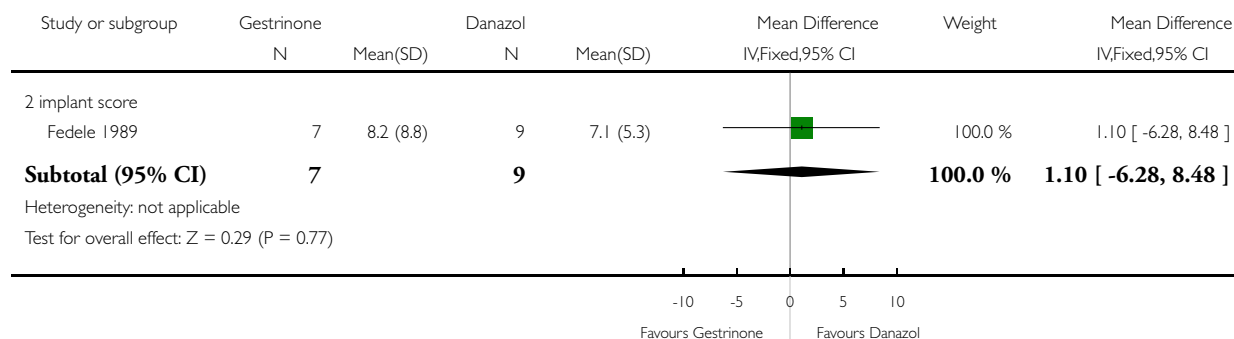
Outcome: 3 Objective assessment of efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

Outcome: 3 Objective assessment of efficacy at end of treatment (6 months)

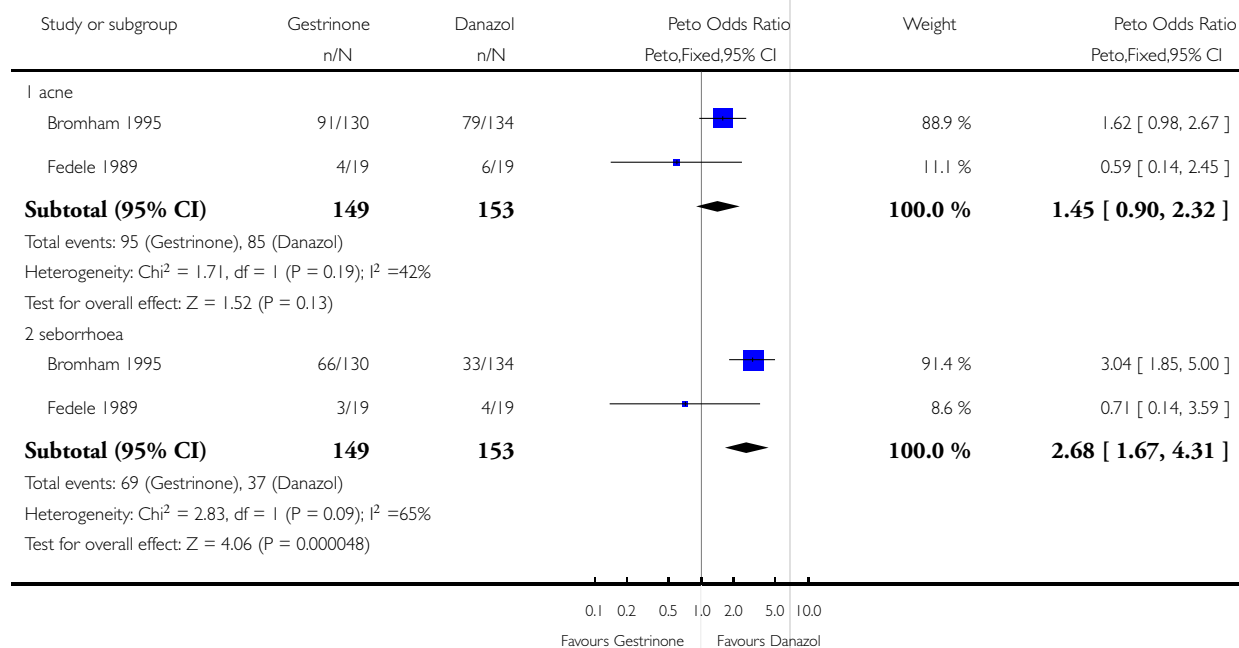


Analysis 10.4. Comparison 10 GESTRINONE VS DANAZOL, Outcome 4 Side effects.

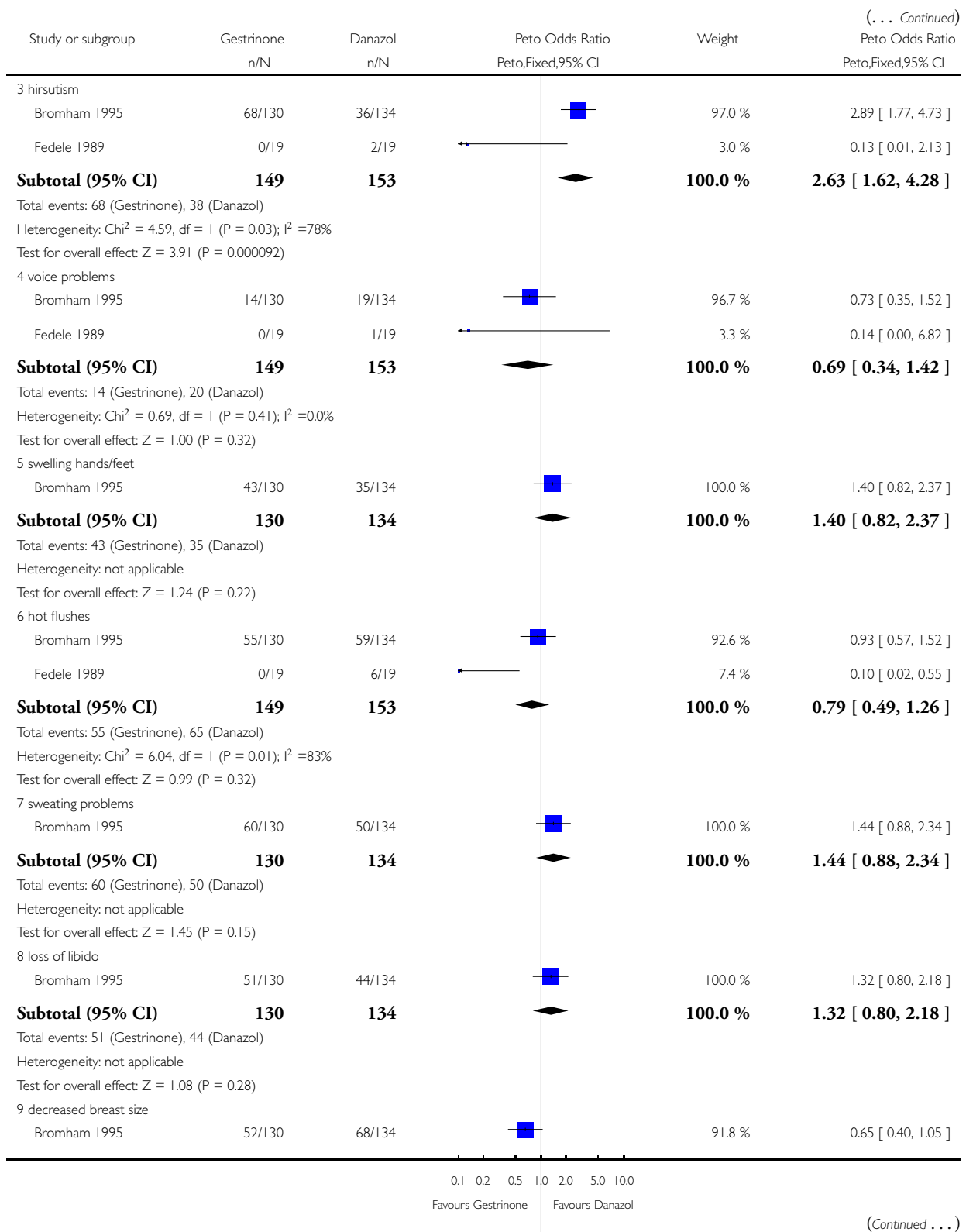
Review: Progestagens and anti-progestagens for pain associated with endometriosis

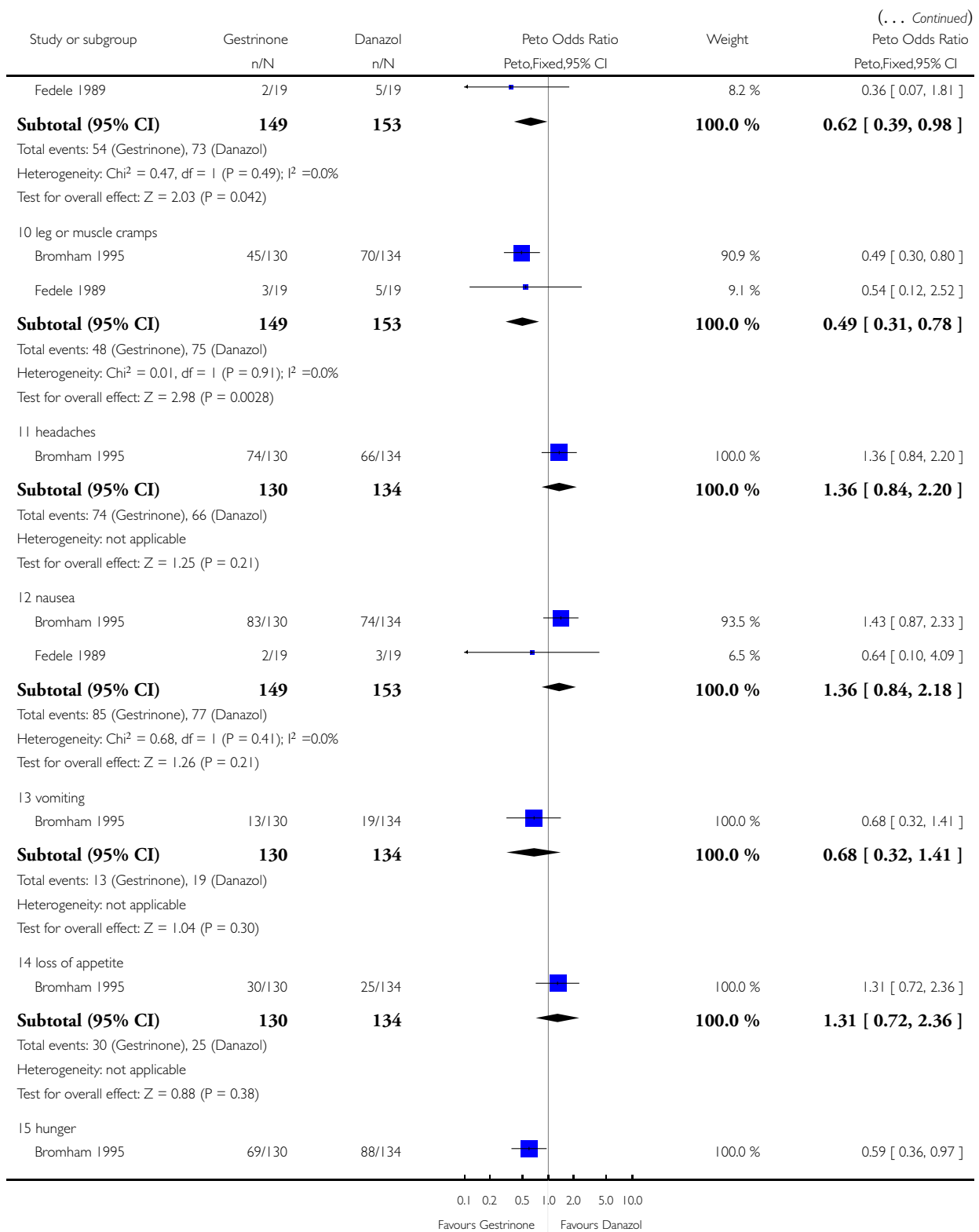
Comparison: 10 GESTRINONE VS DANAZOL

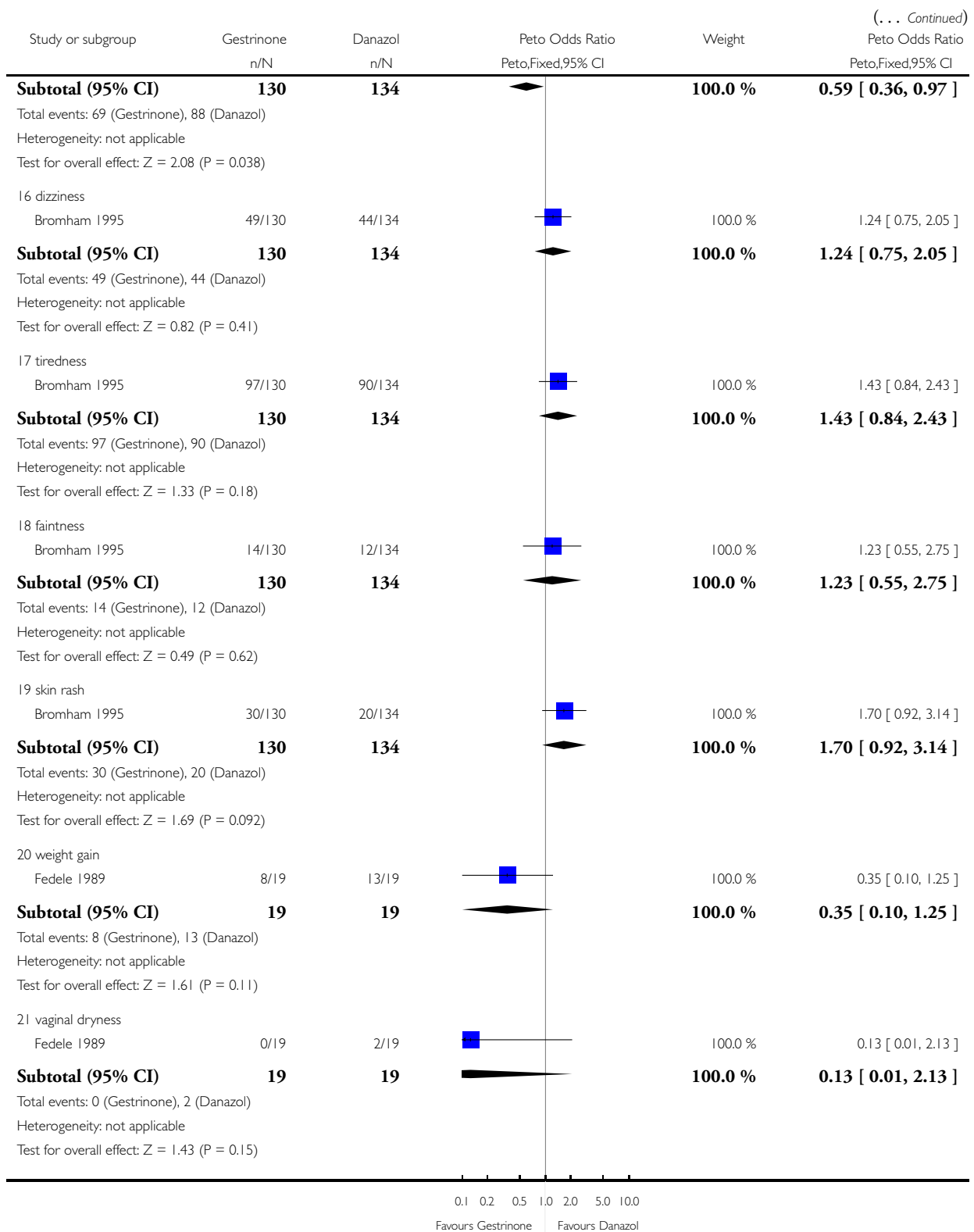
Outcome: 4 Side effects

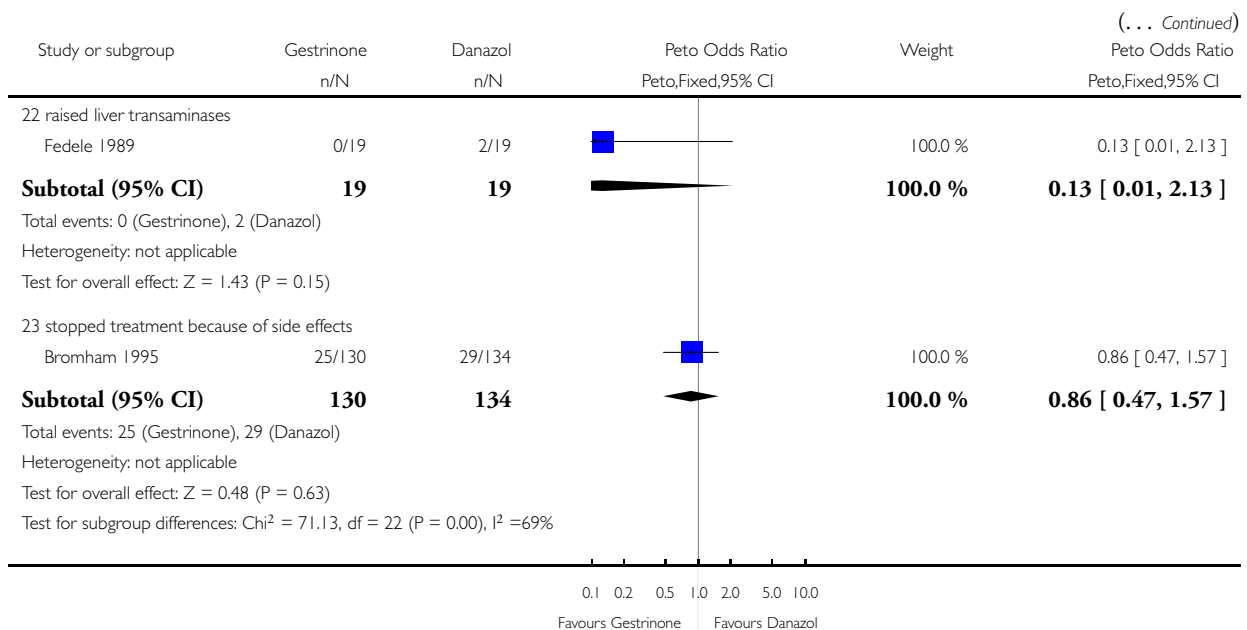


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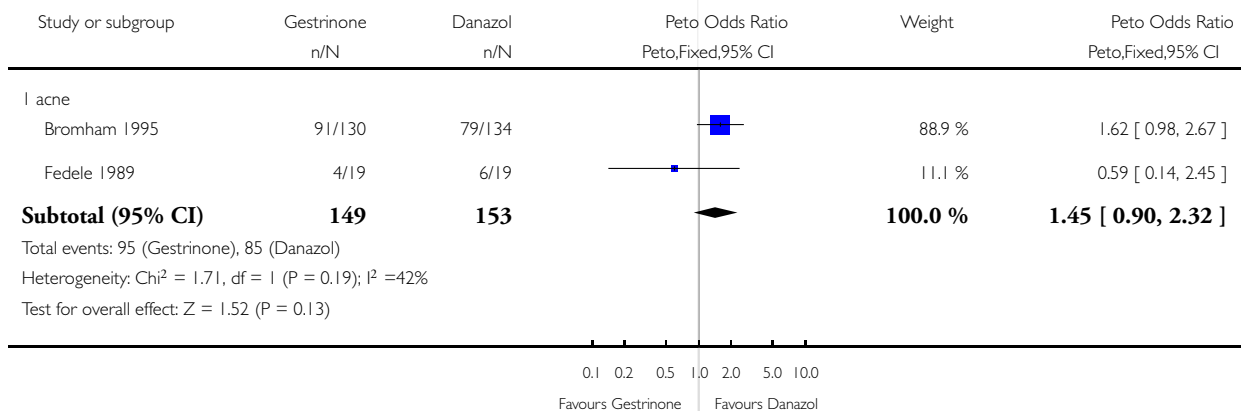




Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

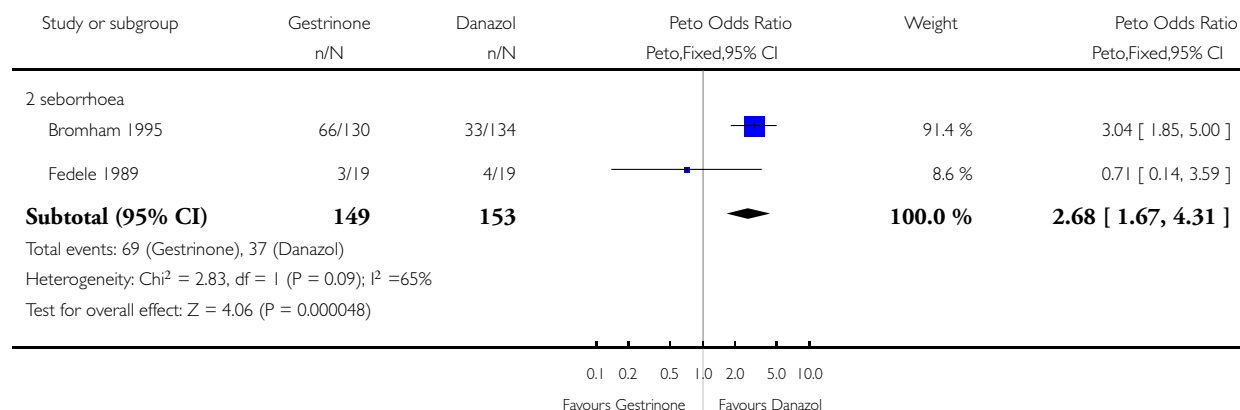
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

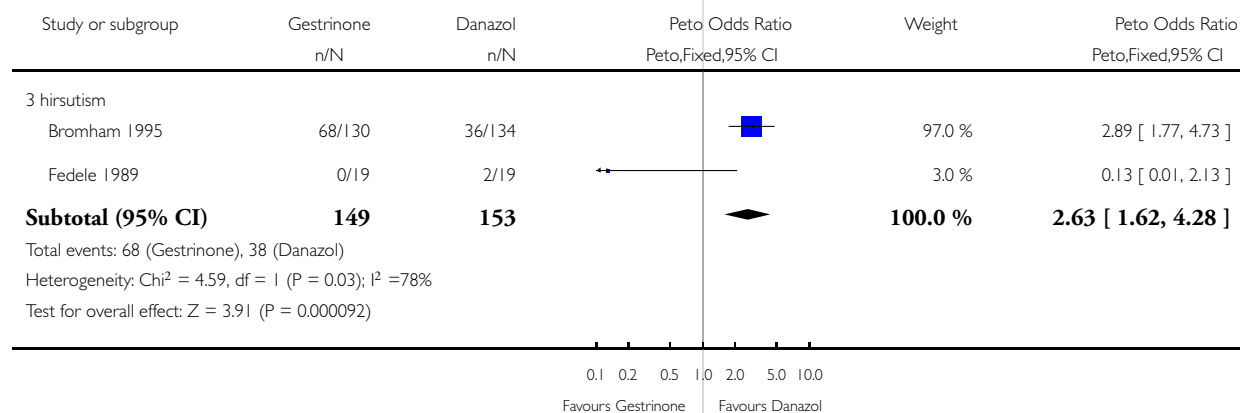
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

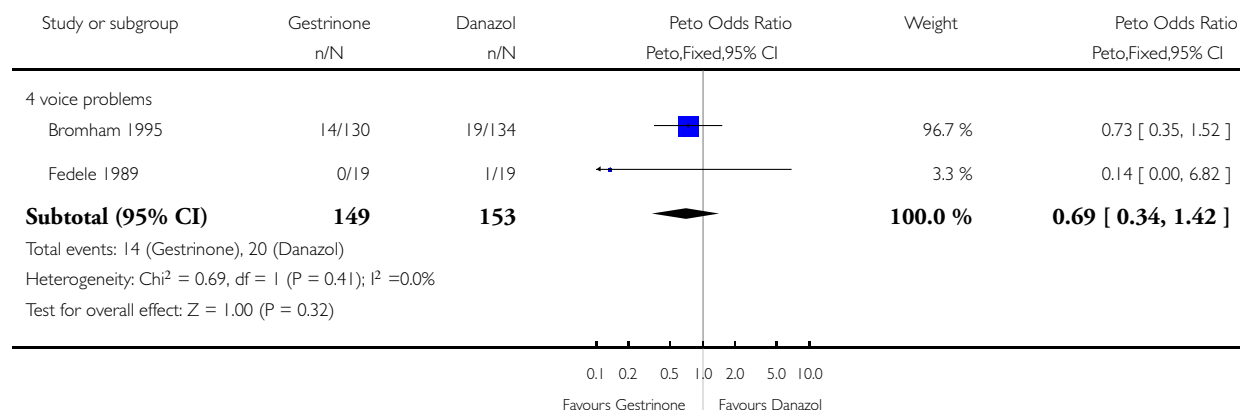
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

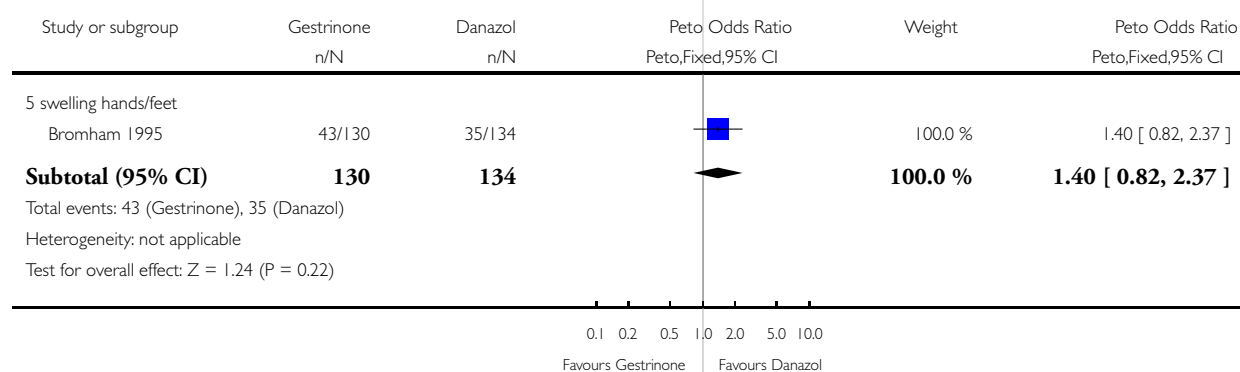
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

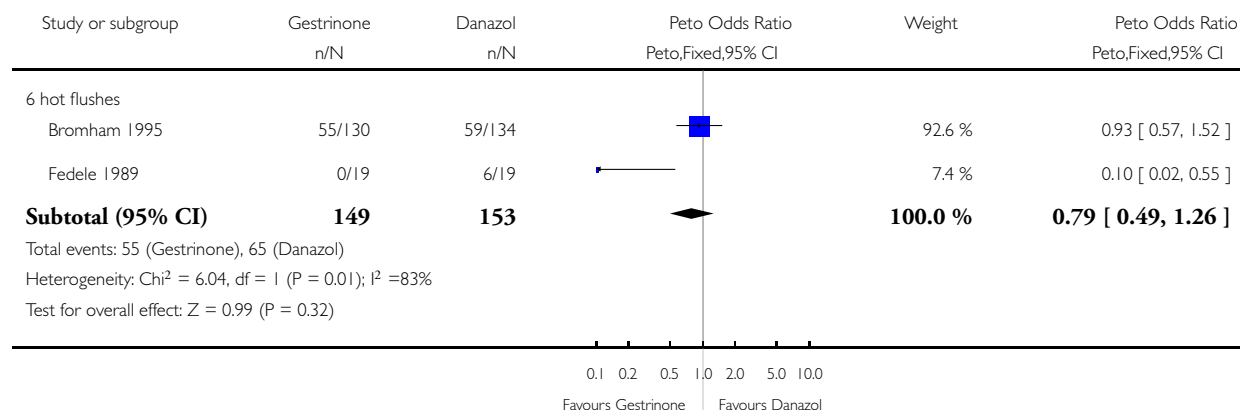
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

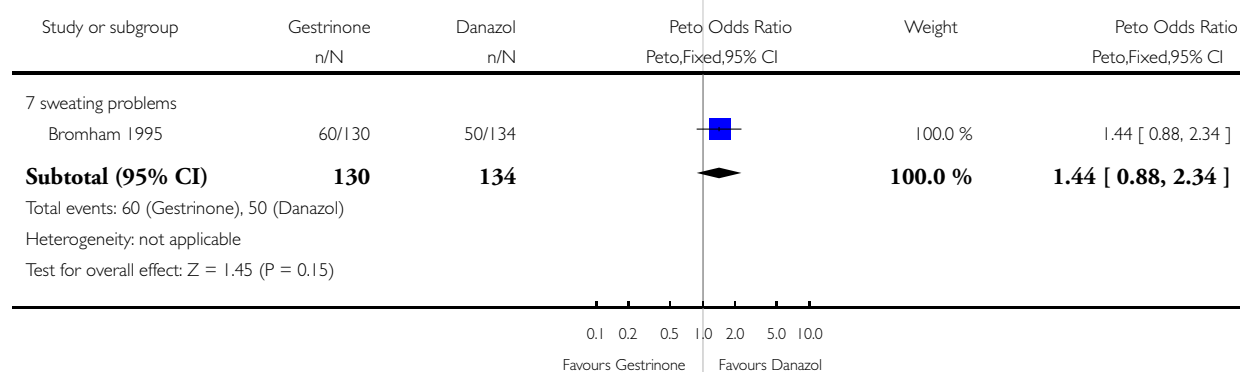
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

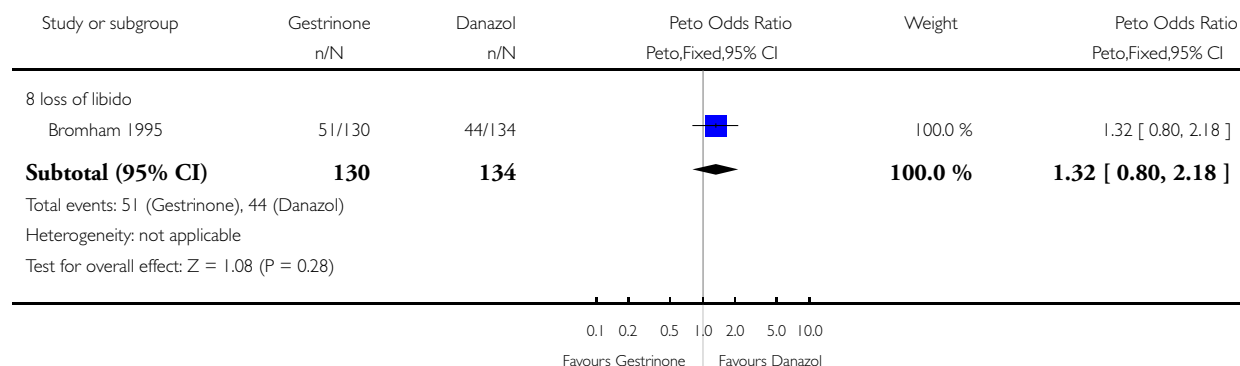
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

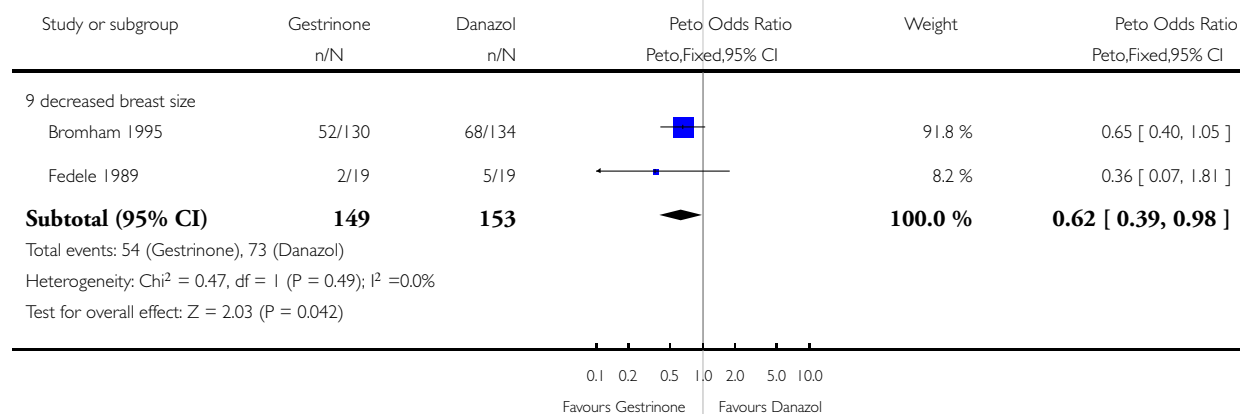
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

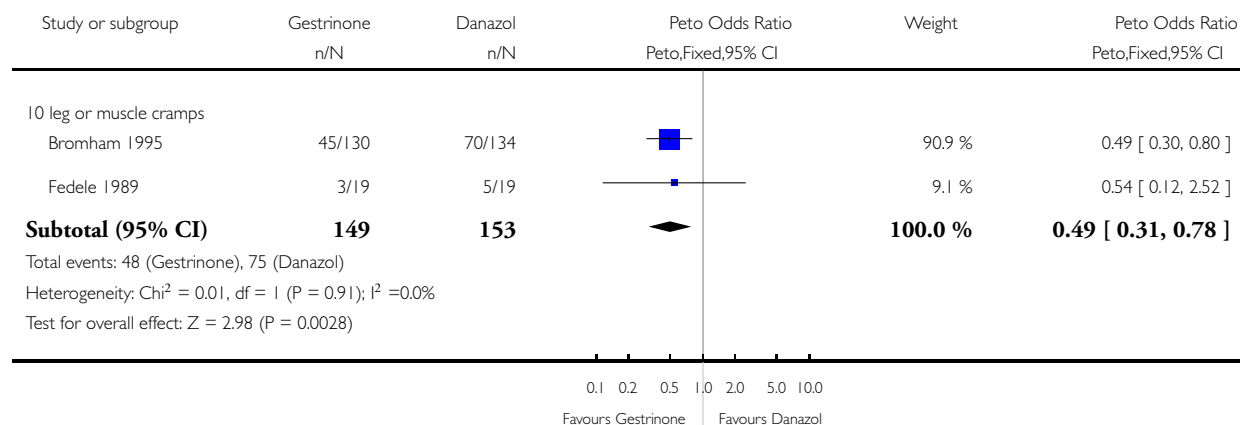
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

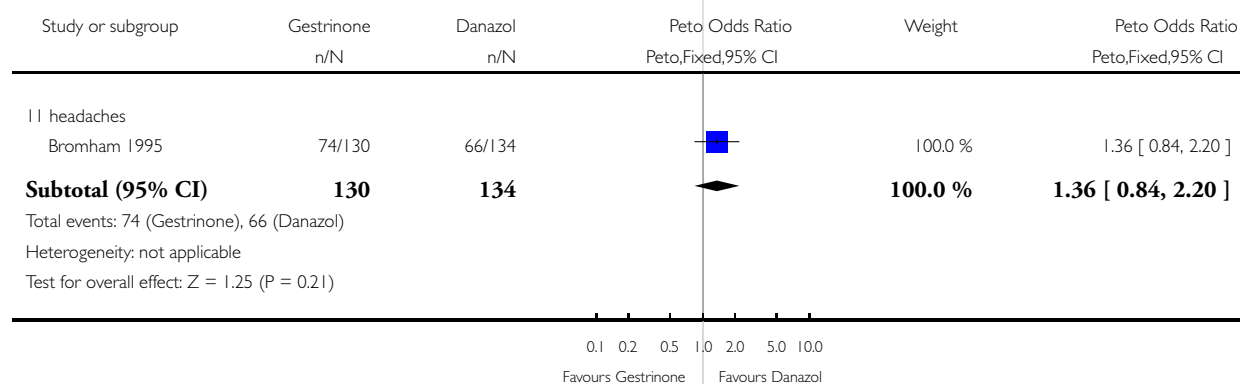
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

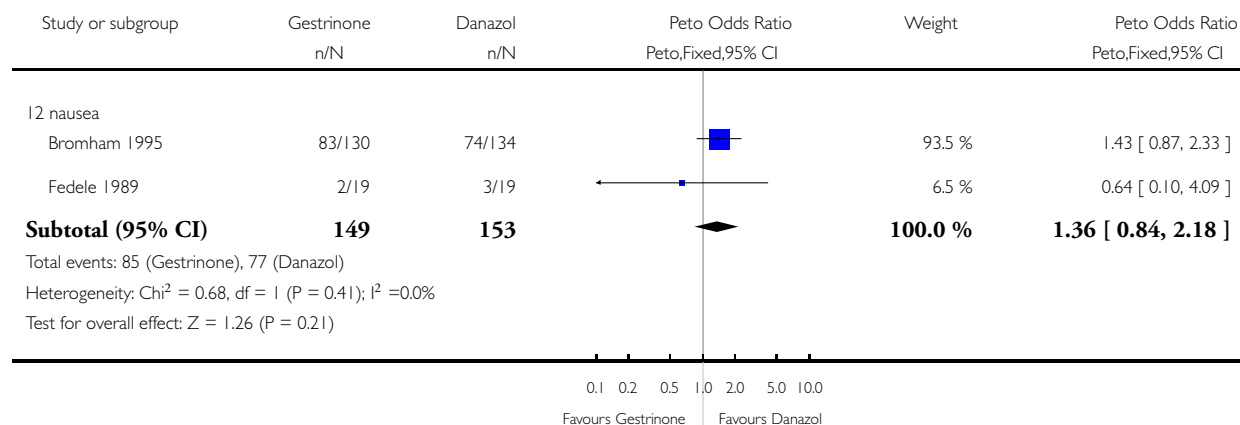
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

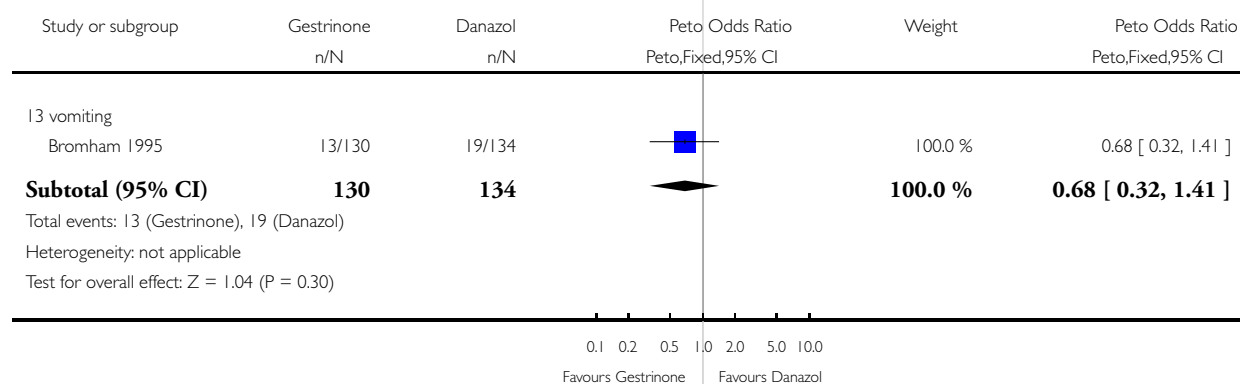
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

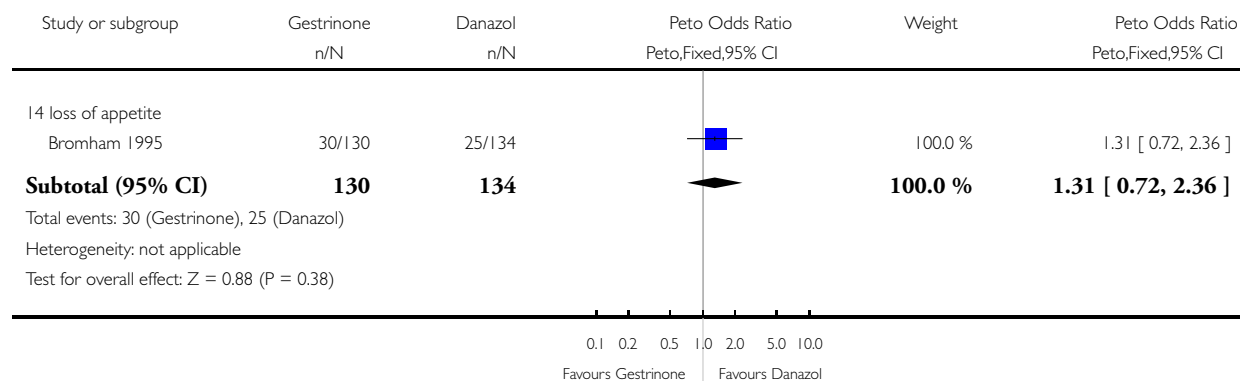
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

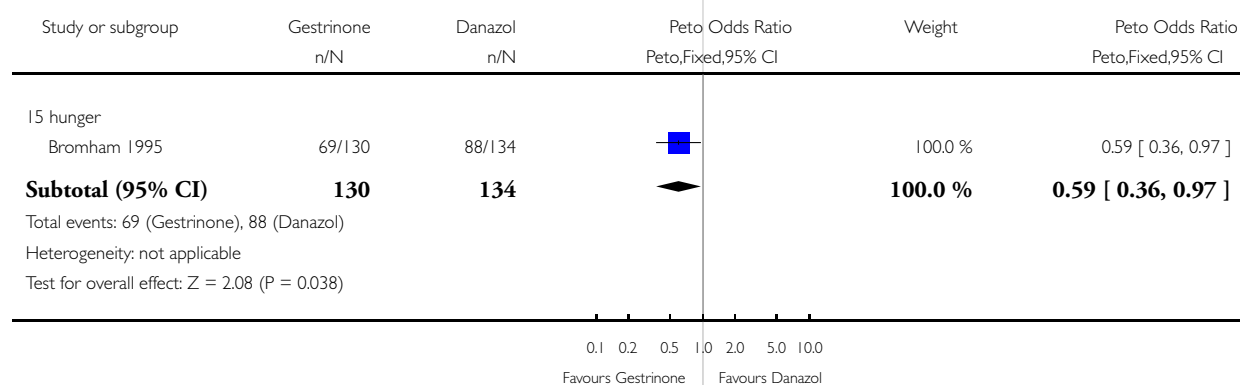
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

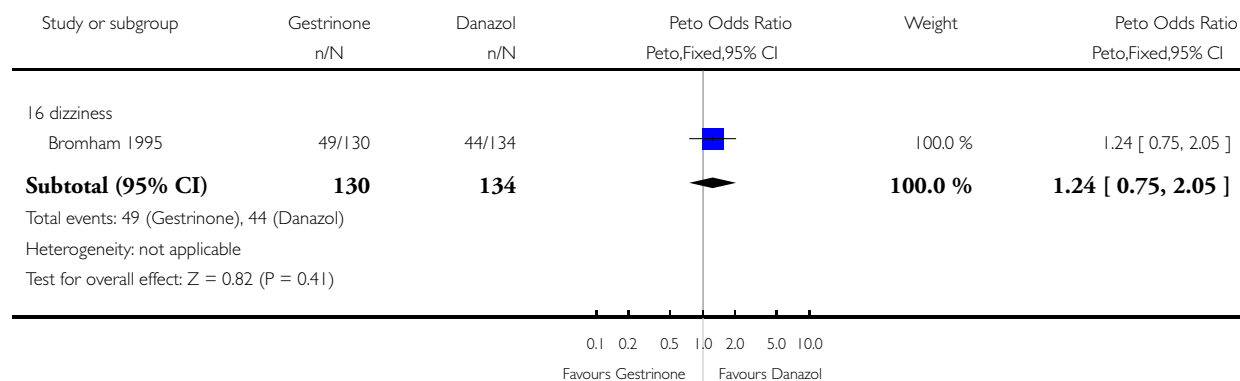
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

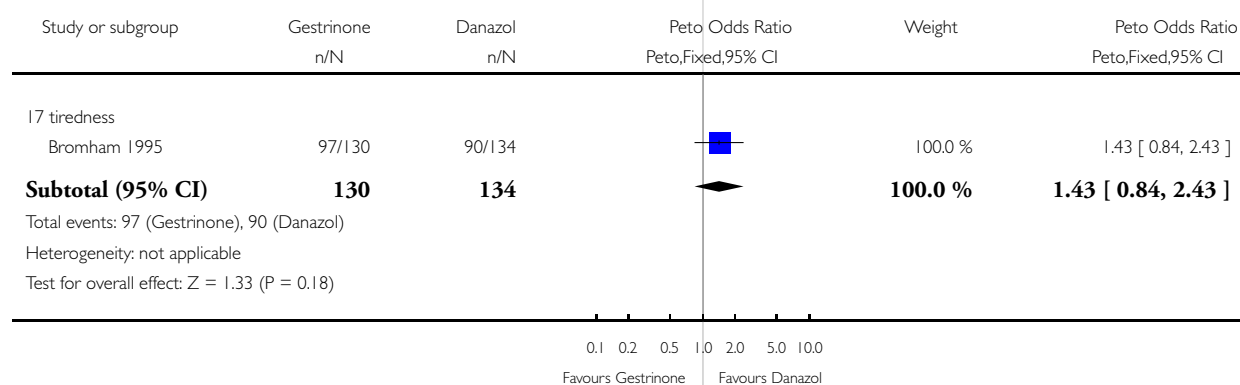
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

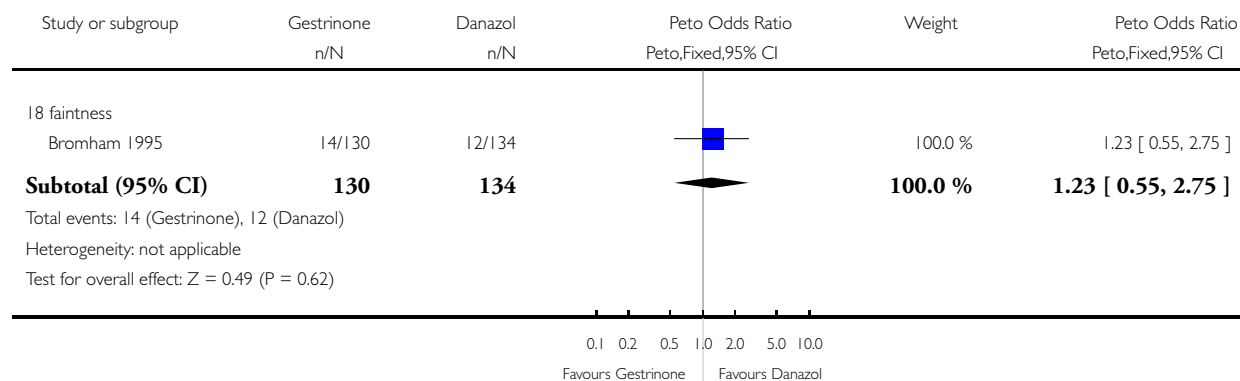
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

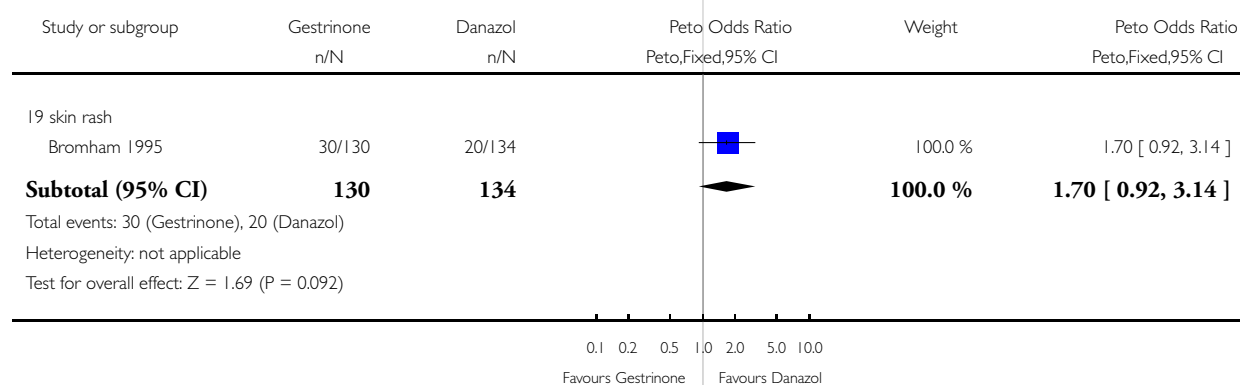
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

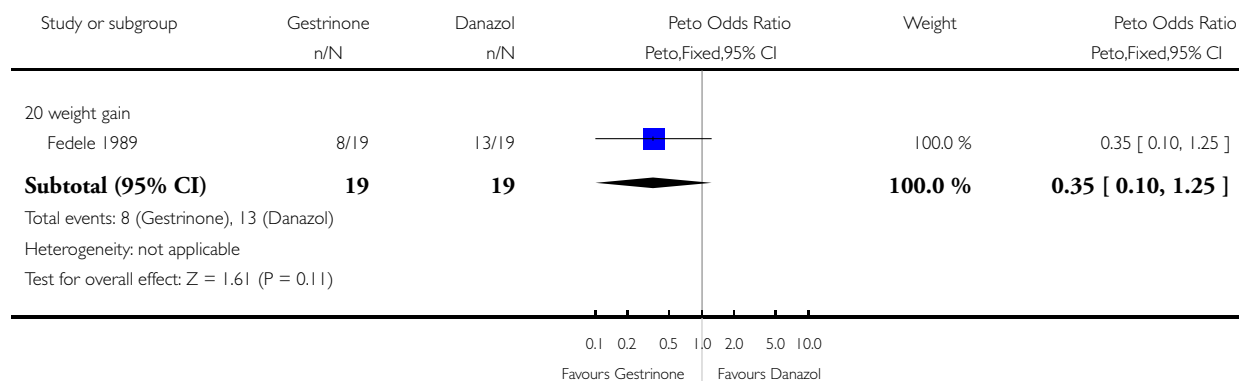
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

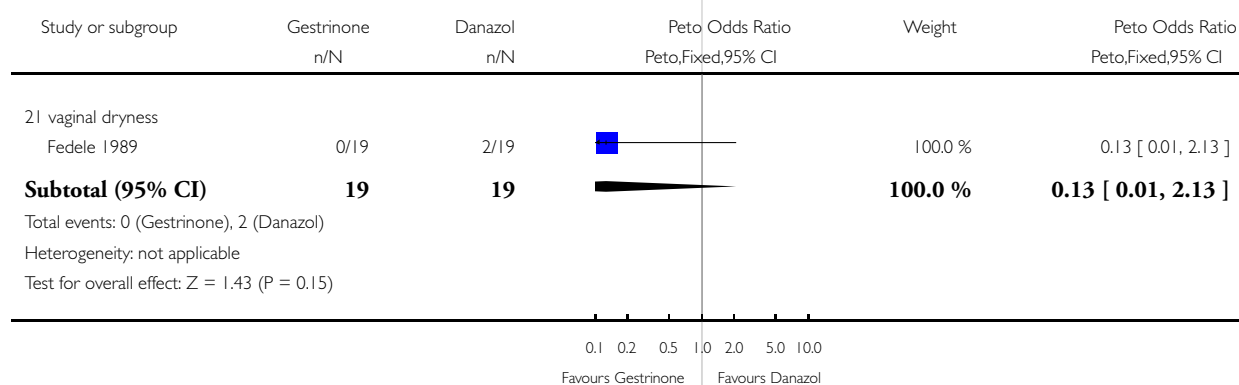
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

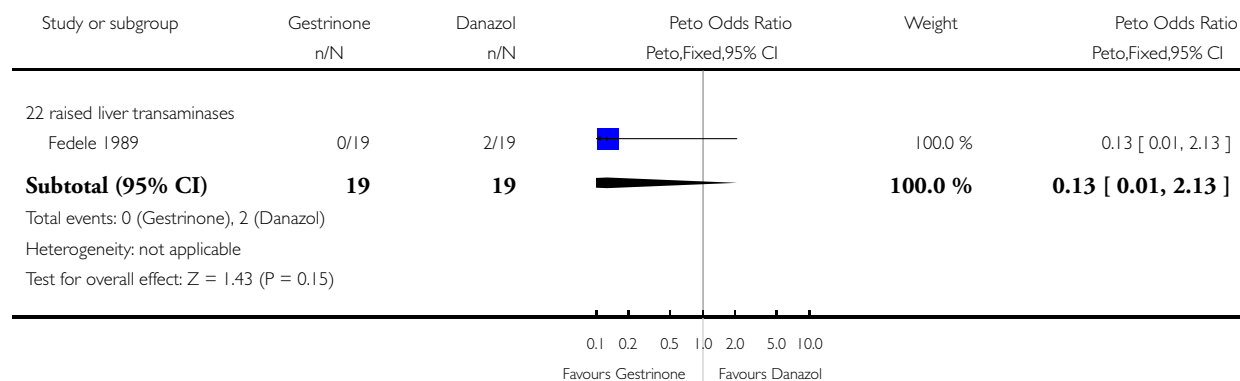
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

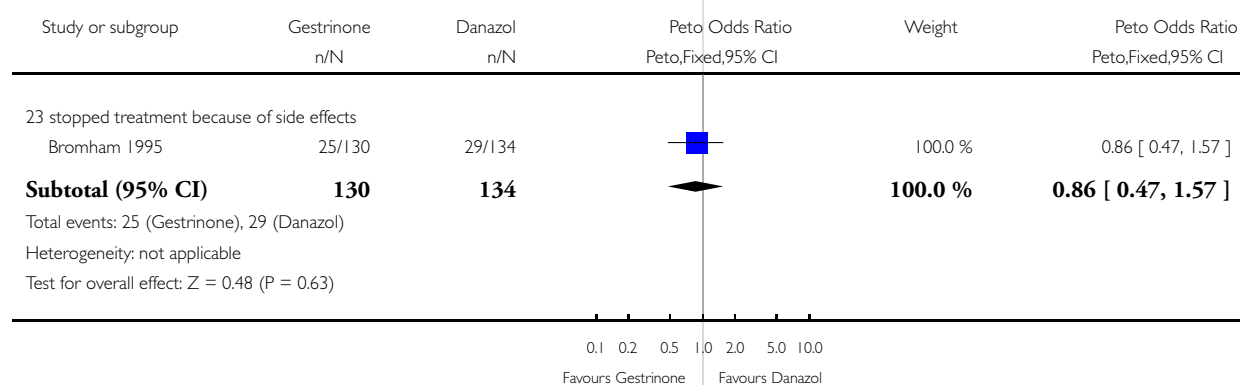
Outcome: 4 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 10 GESTRINONE VS DANAZOL

Outcome: 4 Side effects

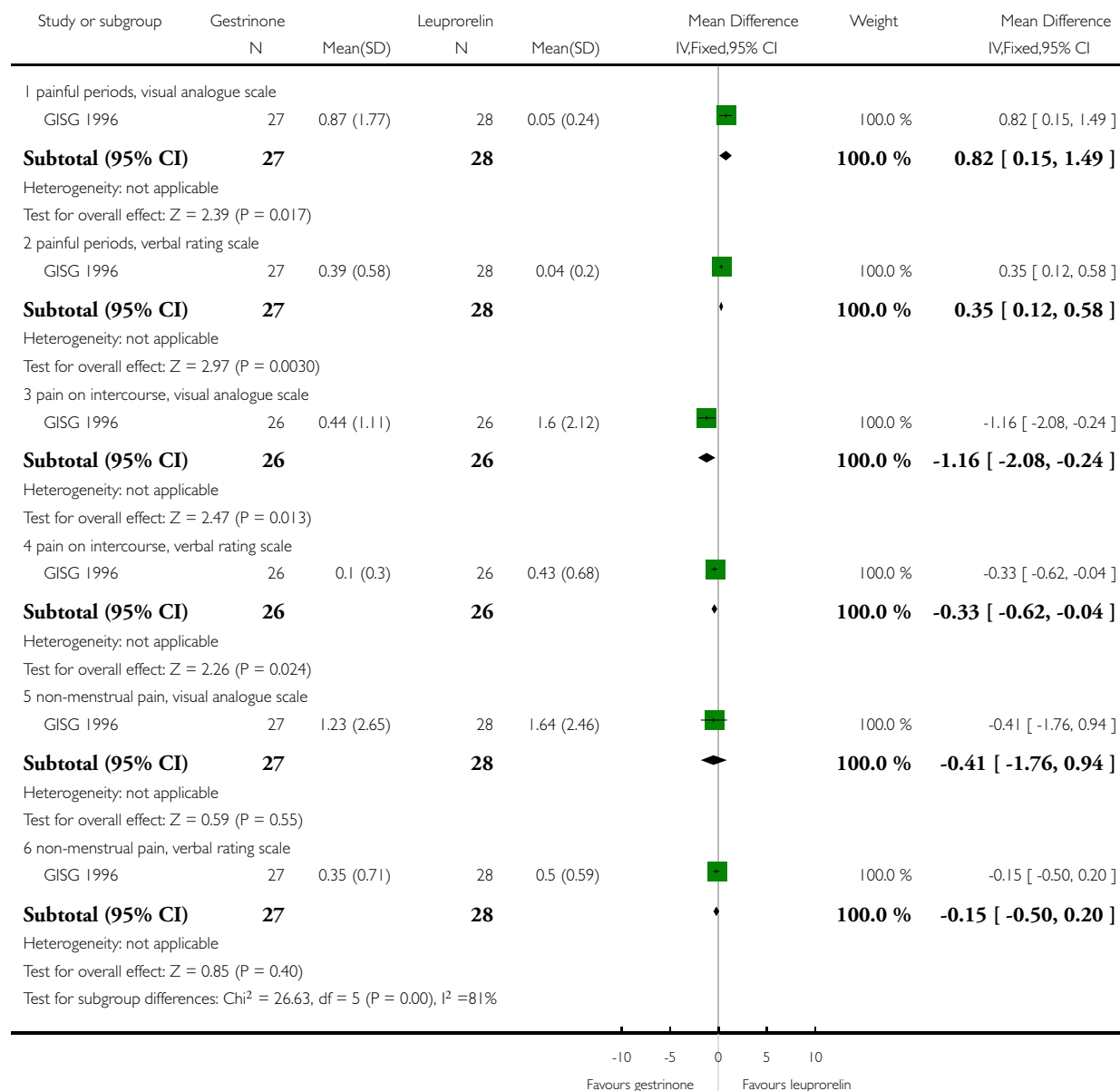


Analysis 11.1. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 1 Patient assessed efficacy at end of treatment (6 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

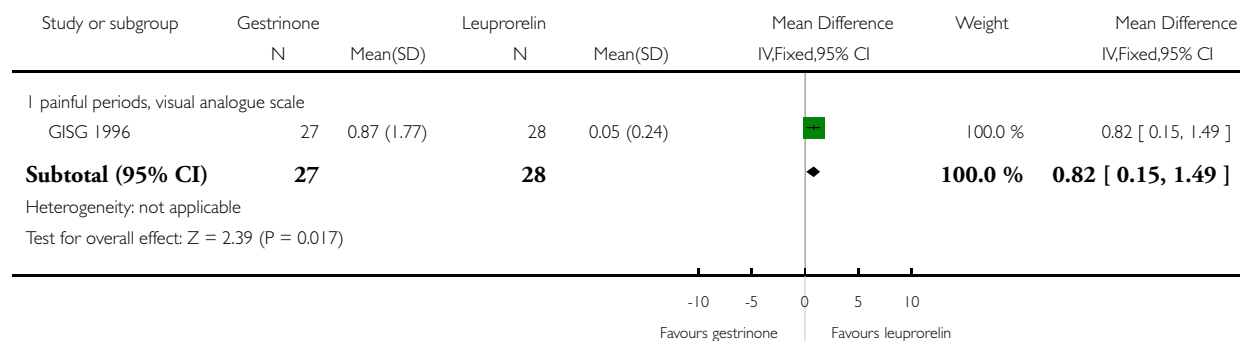
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

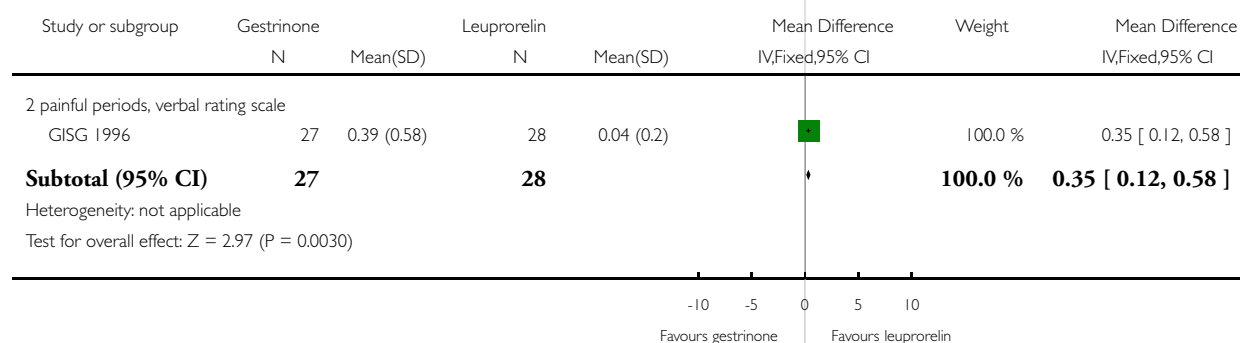
Outcome: 1 | Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

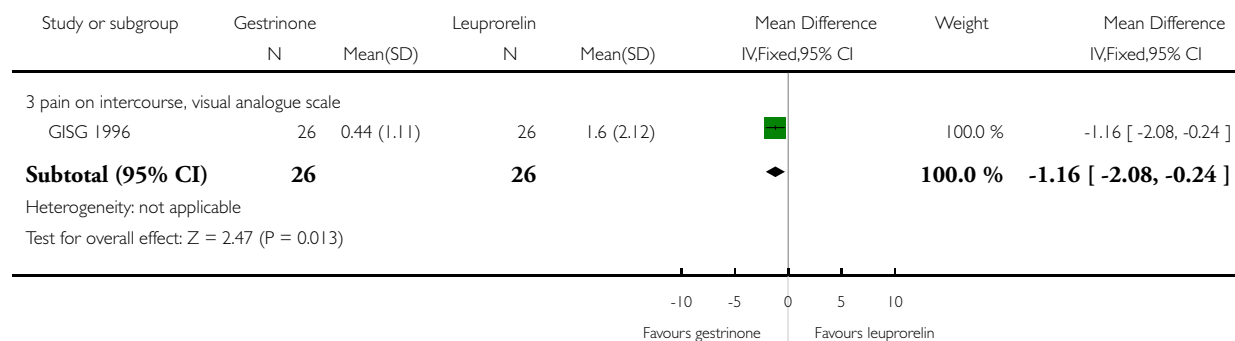
Outcome: 1 | Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

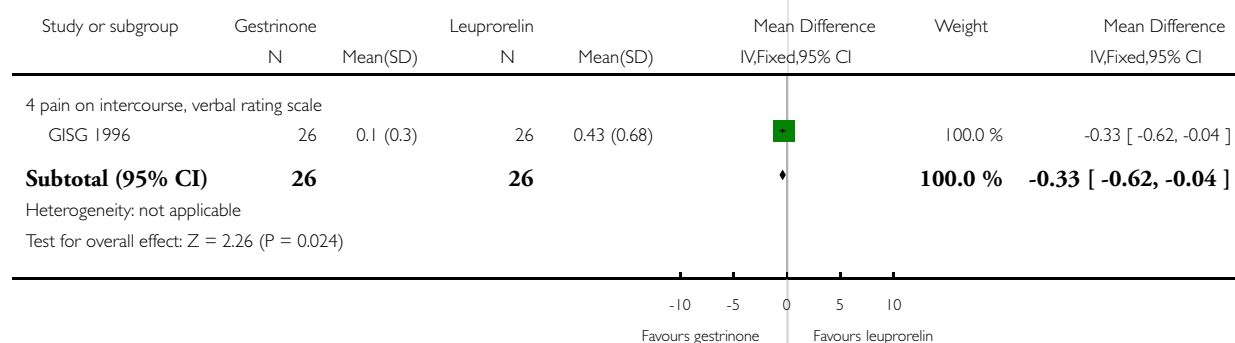
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

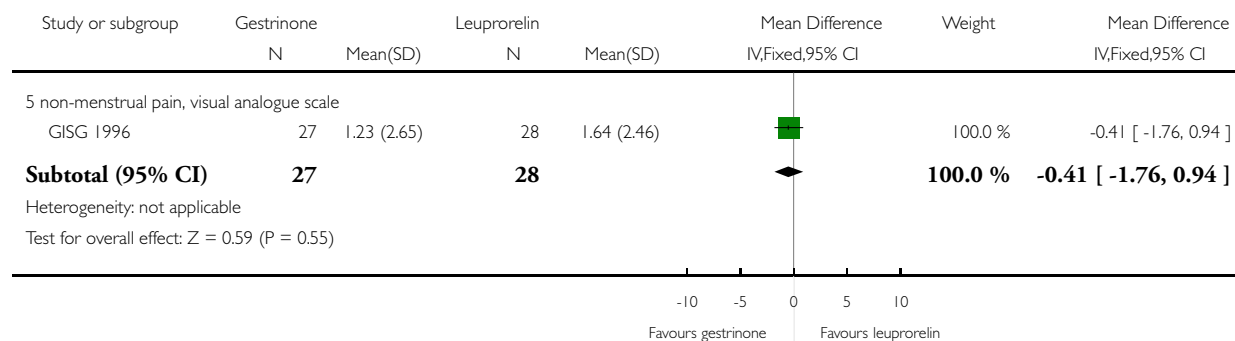
Outcome: 1 Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: I I GESTRINONE VS GnRH ANALOGUE

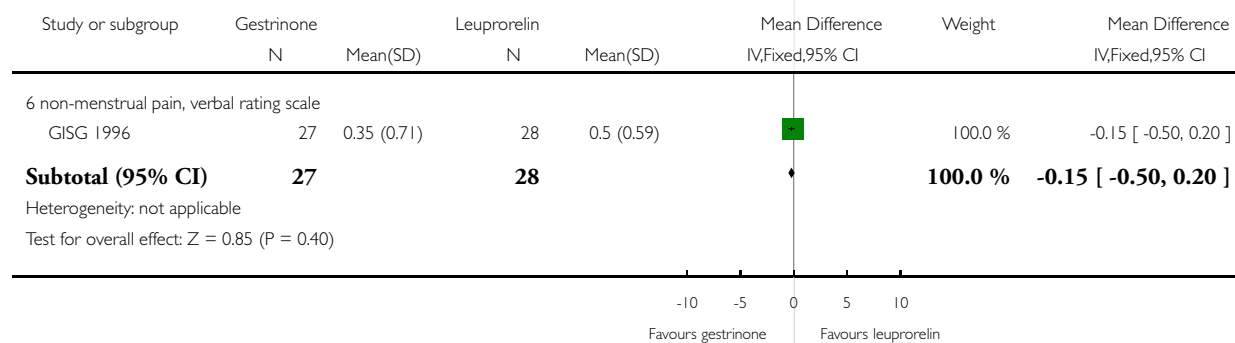
Outcome: I Patient assessed efficacy at end of treatment (6 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: I I GESTRINONE VS GnRH ANALOGUE

Outcome: I Patient assessed efficacy at end of treatment (6 months)

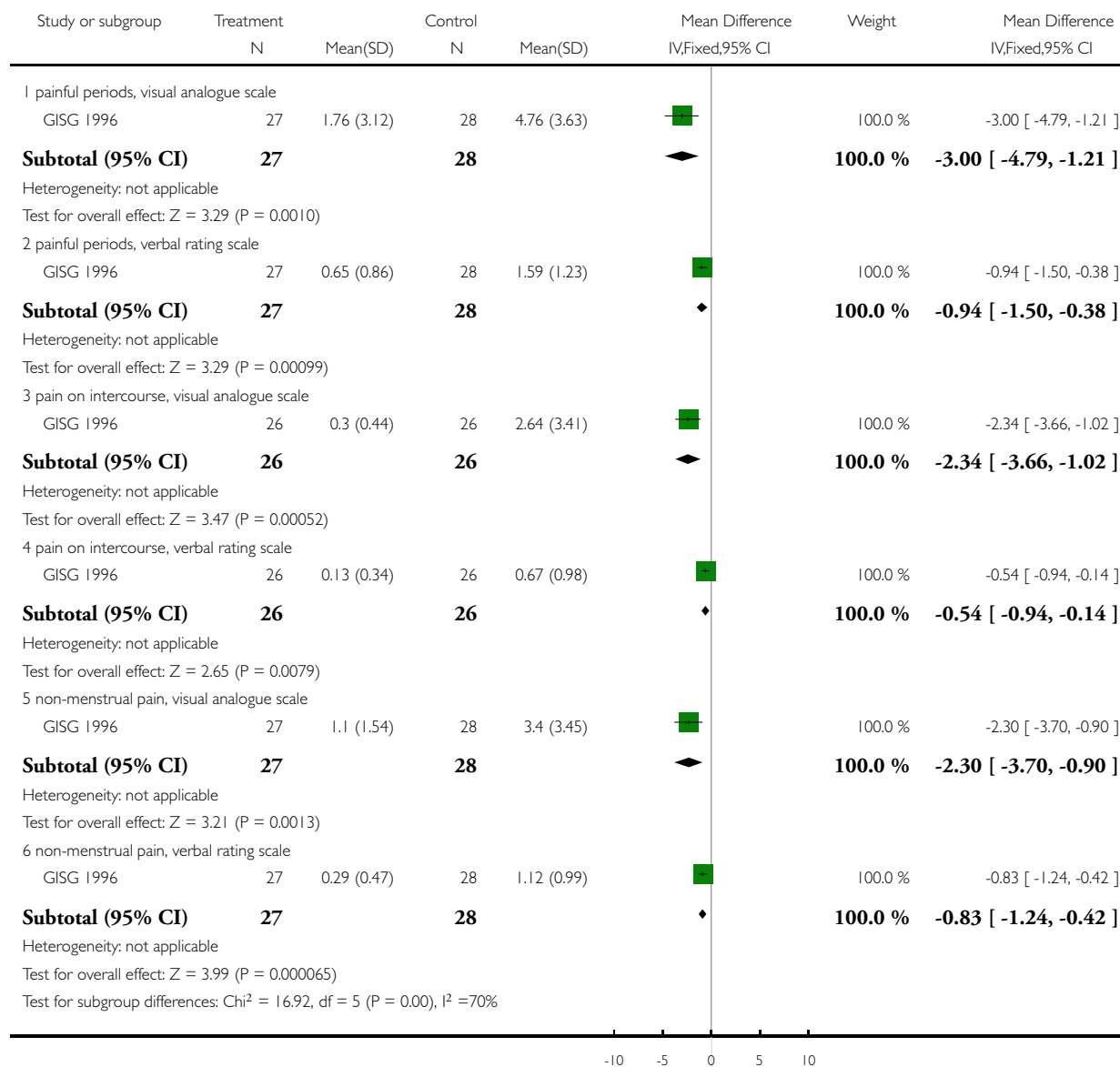


Analysis 11.2. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 2 Patient assessed efficacy at end of follow-up (12 months).

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

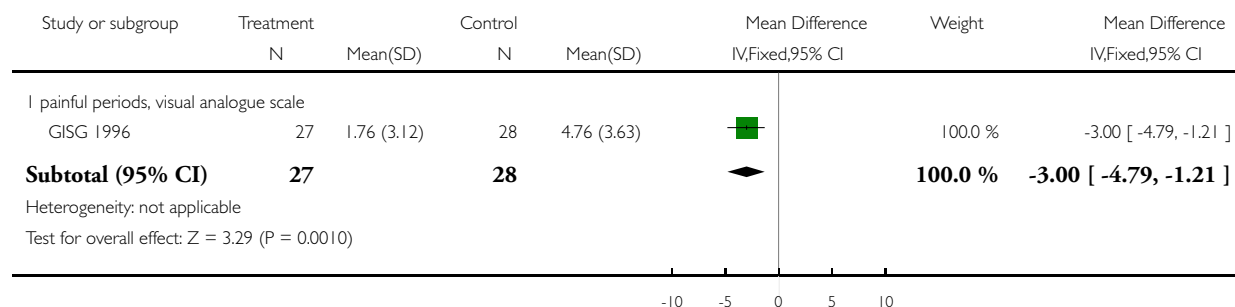
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 1 GESTRINONE VS GnRH ANALOGUE

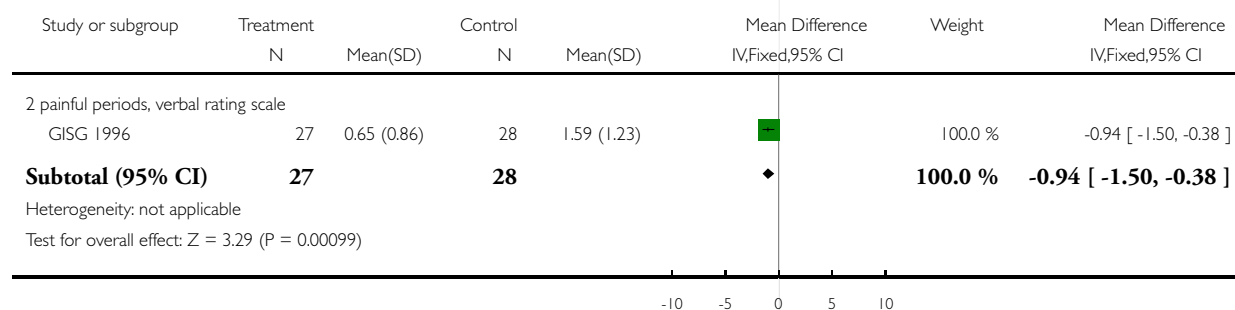
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 1 GESTRINONE VS GnRH ANALOGUE

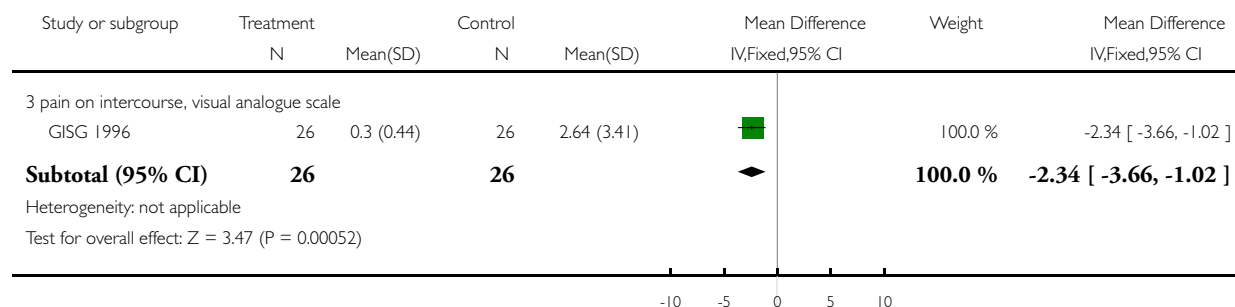
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

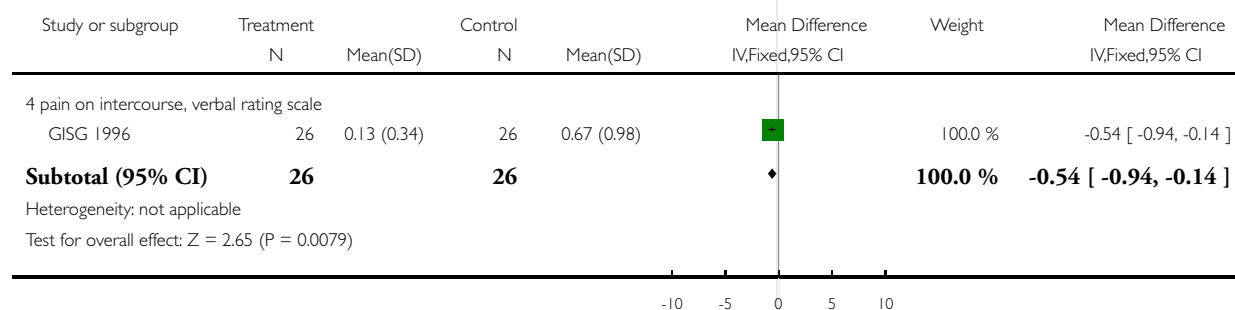
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

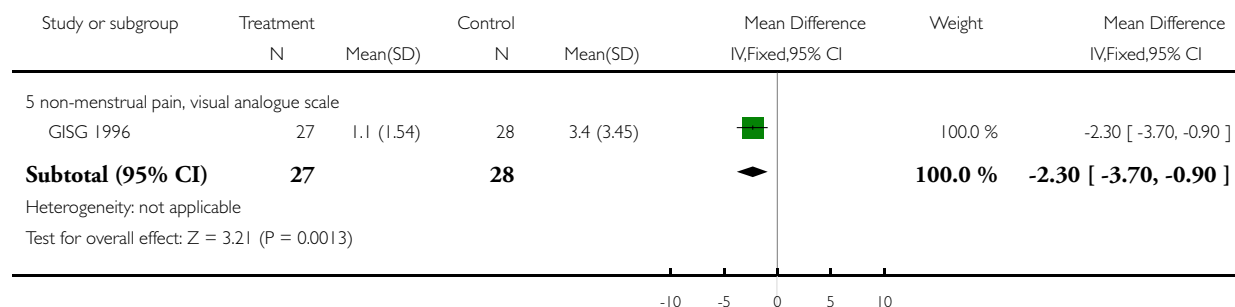
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

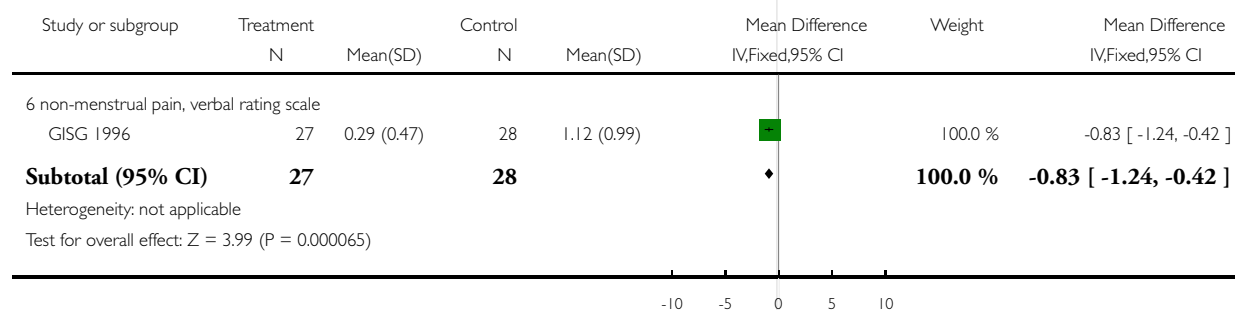
Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 1 | GESTRINONE VS GnRH ANALOGUE

Outcome: 2 Patient assessed efficacy at end of follow-up (12 months)

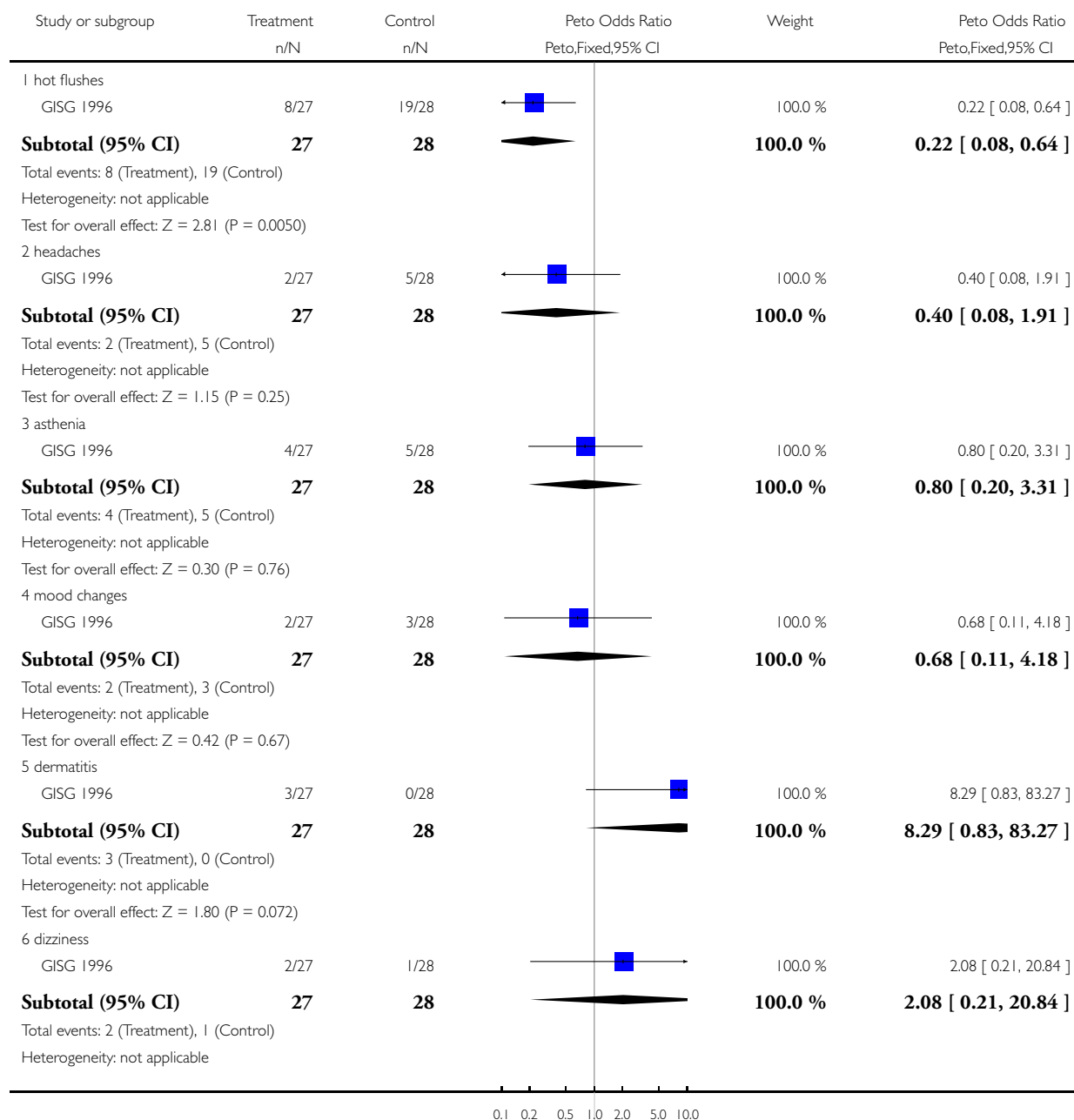


Analysis 11.3. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 3 Side effects.

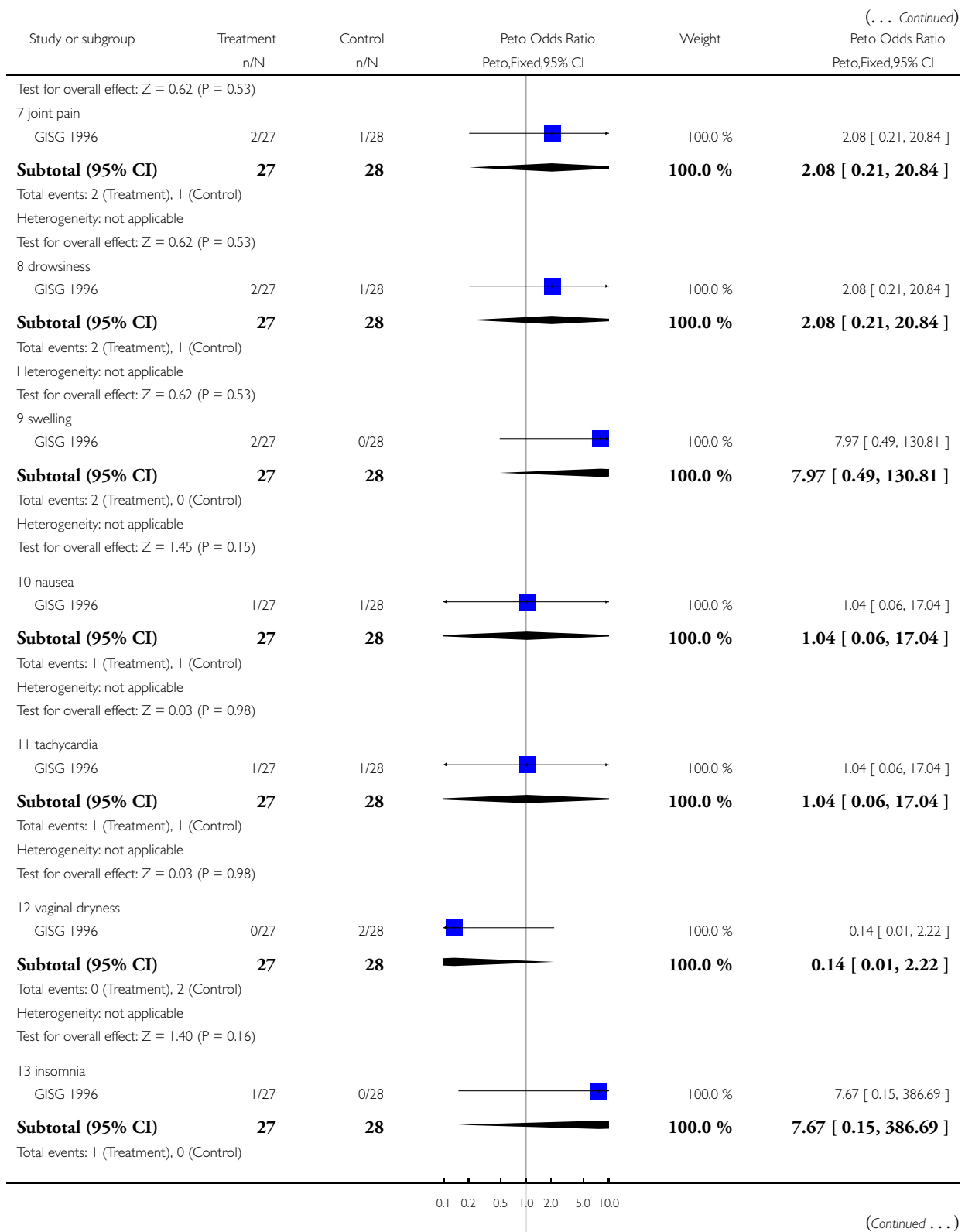
Review: Progestagens and anti-progestagens for pain associated with endometriosis

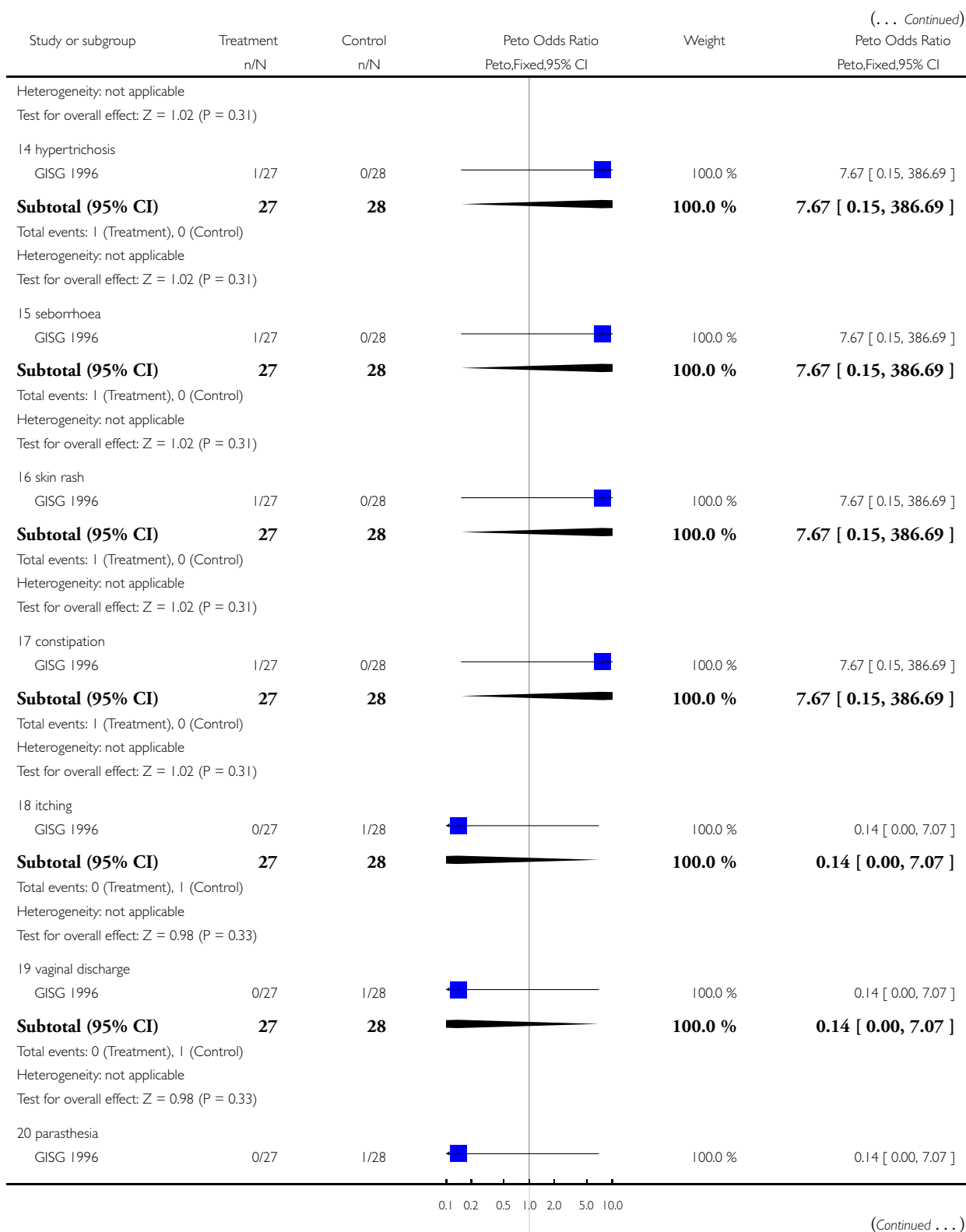
Comparison: 11 GESTRINONE VS GnRH ANALOGUE

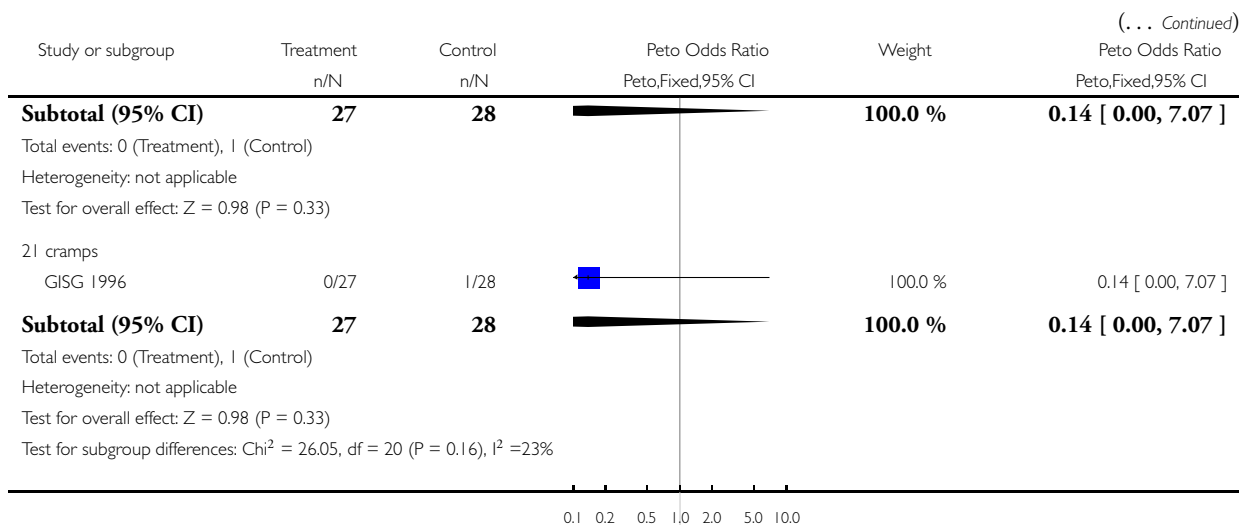
Outcome: 3 Side effects



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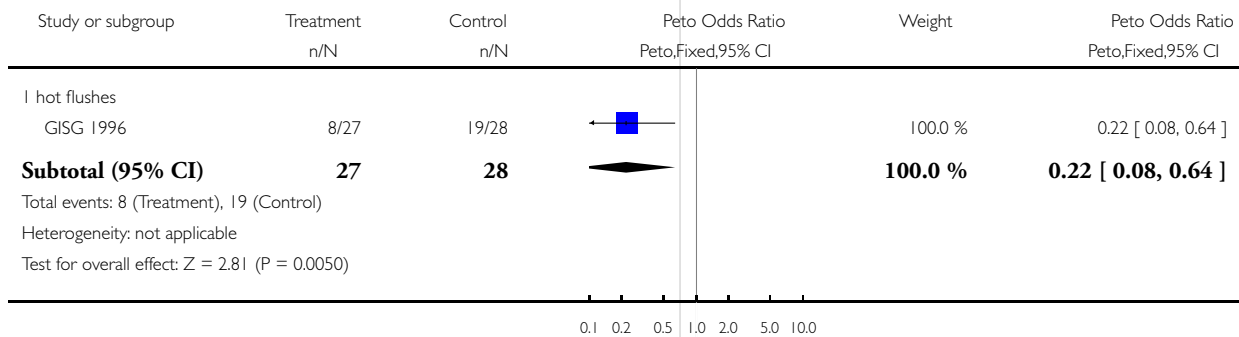




Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

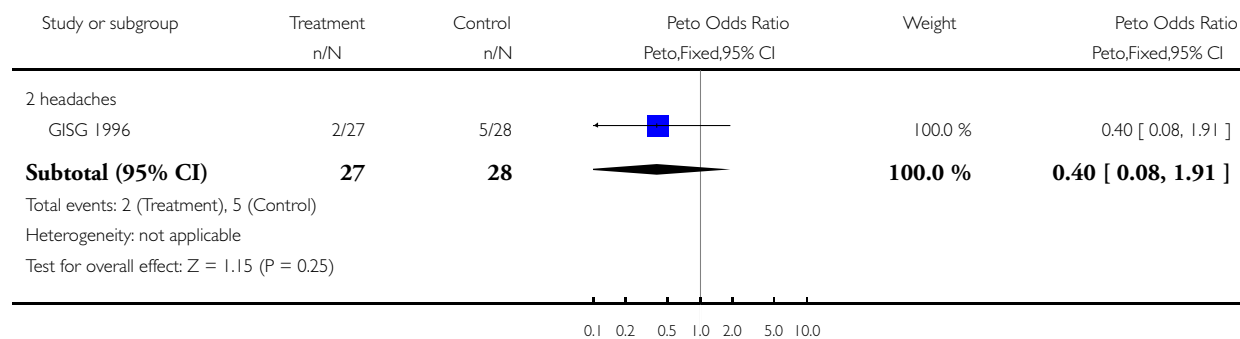
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

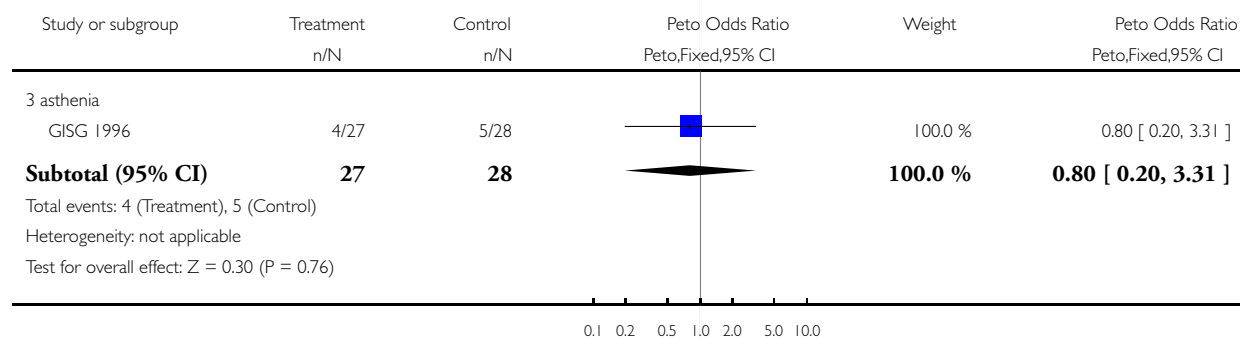
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

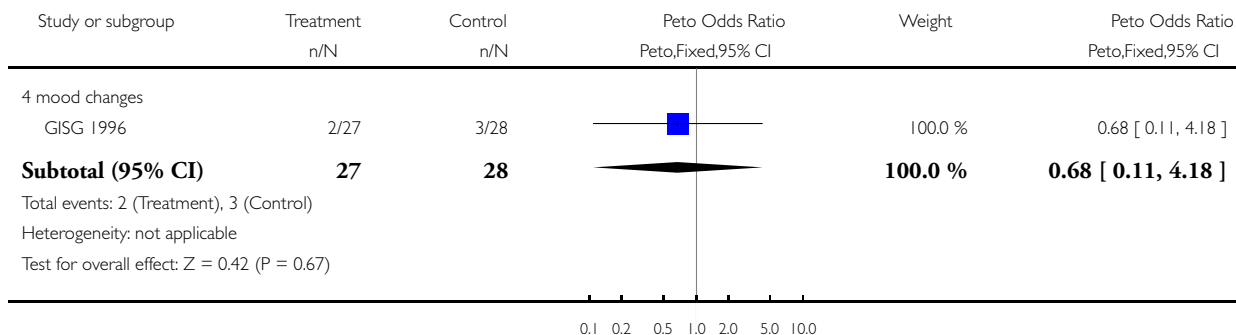
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

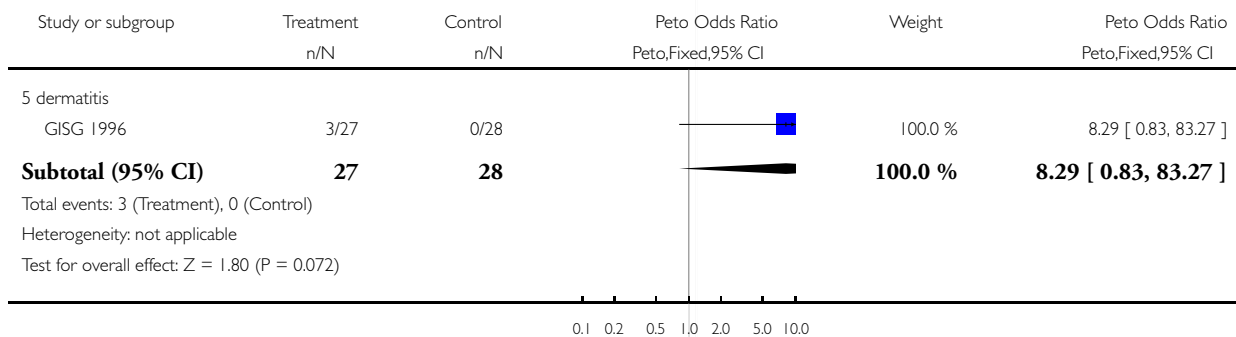
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

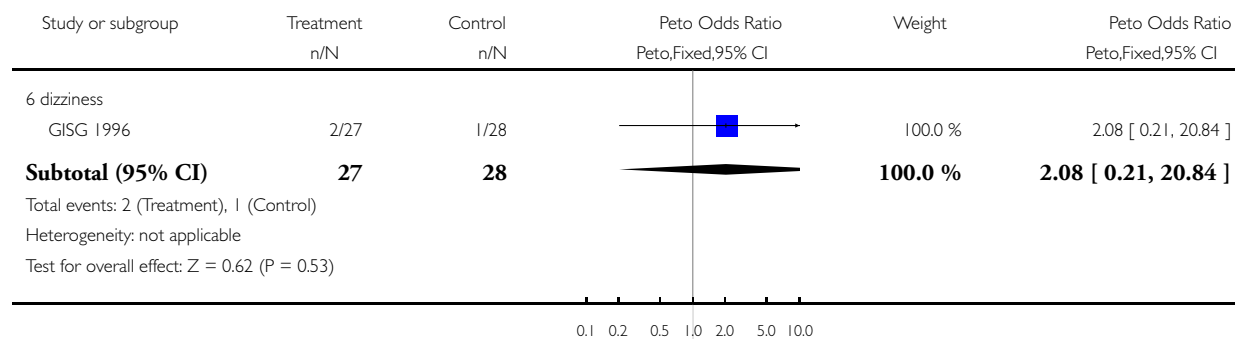
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

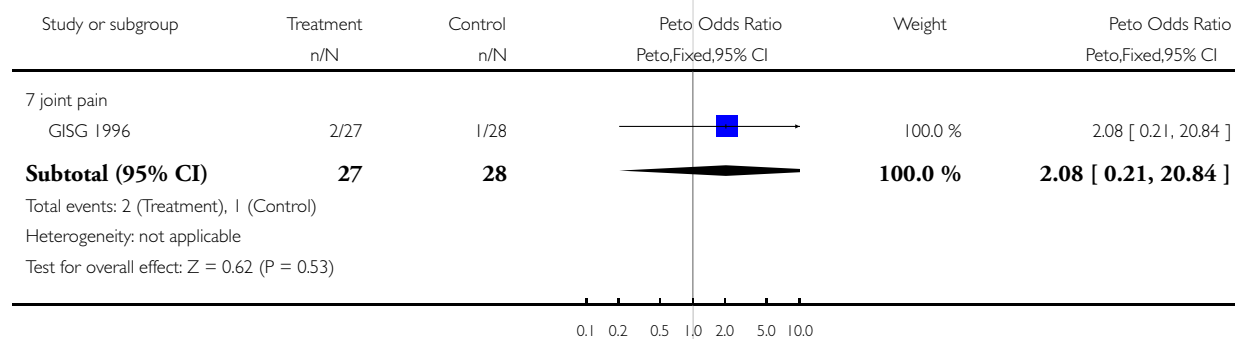
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

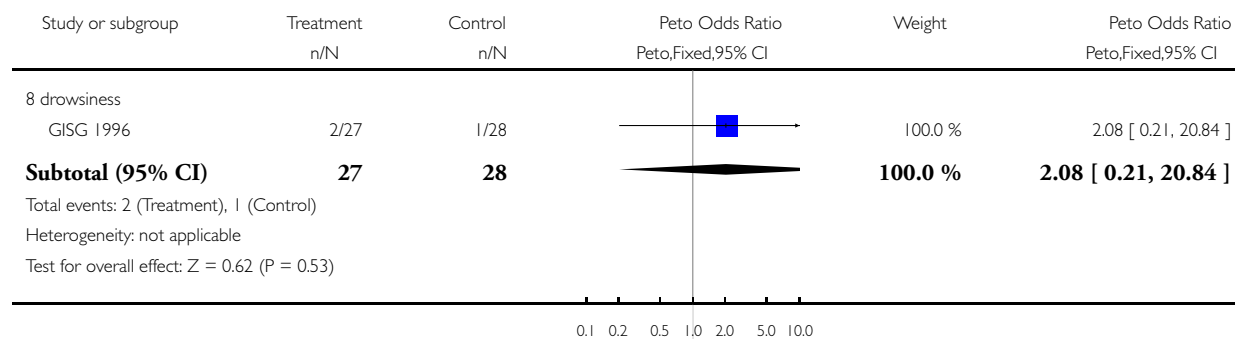
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

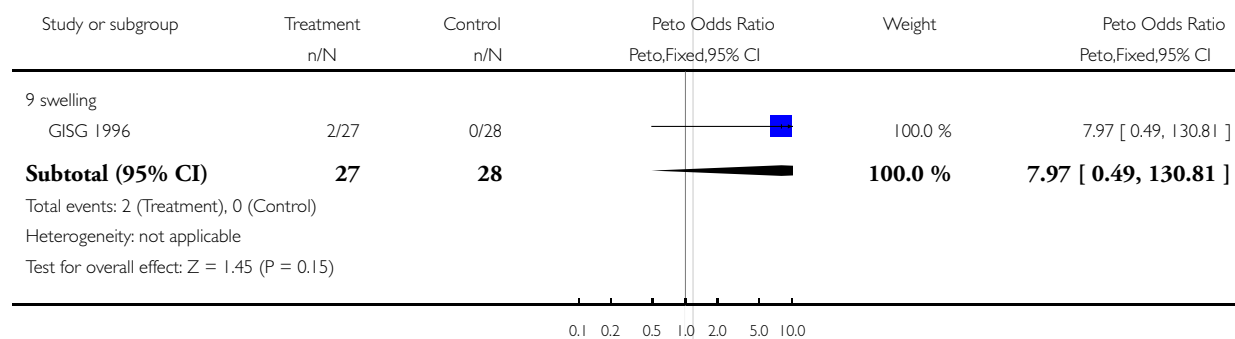
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

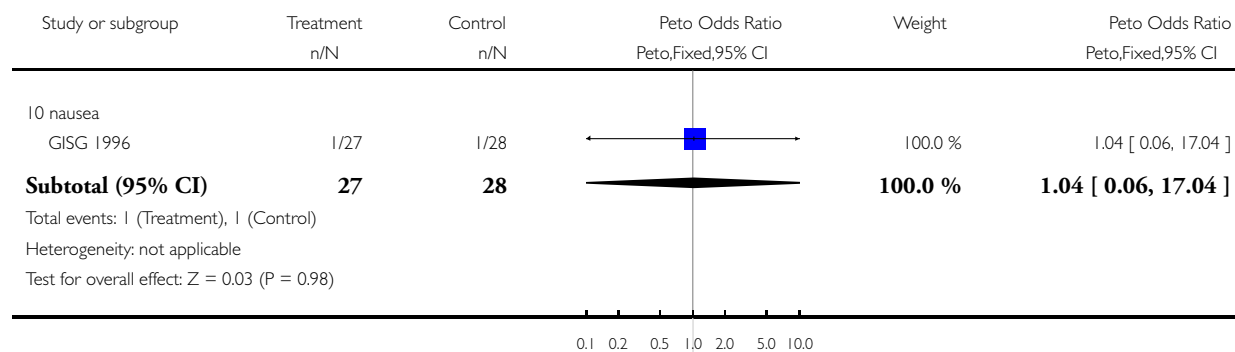
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

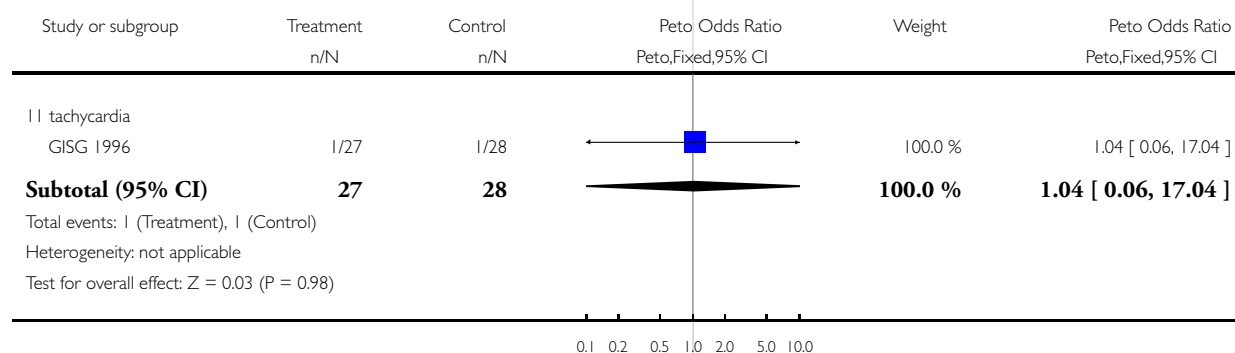
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

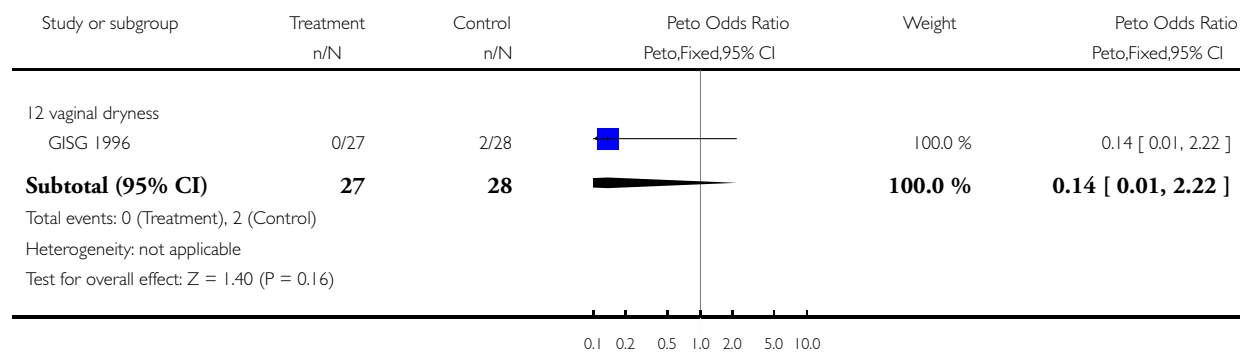
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

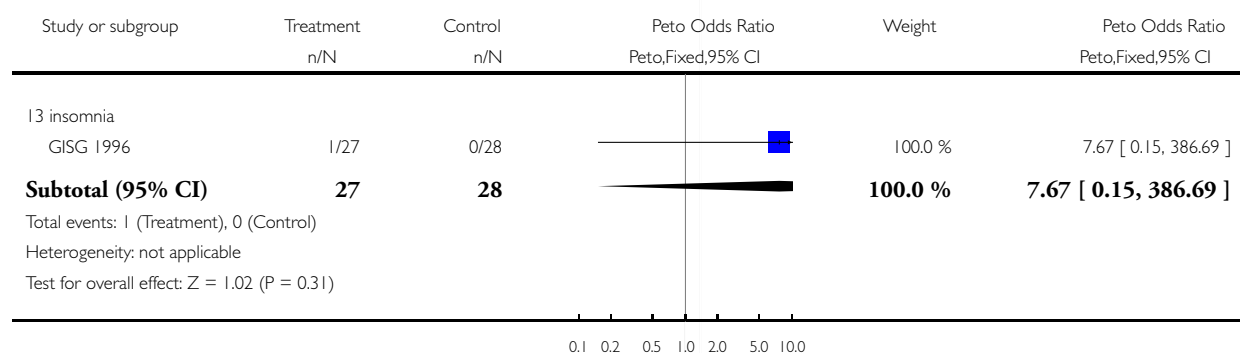
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

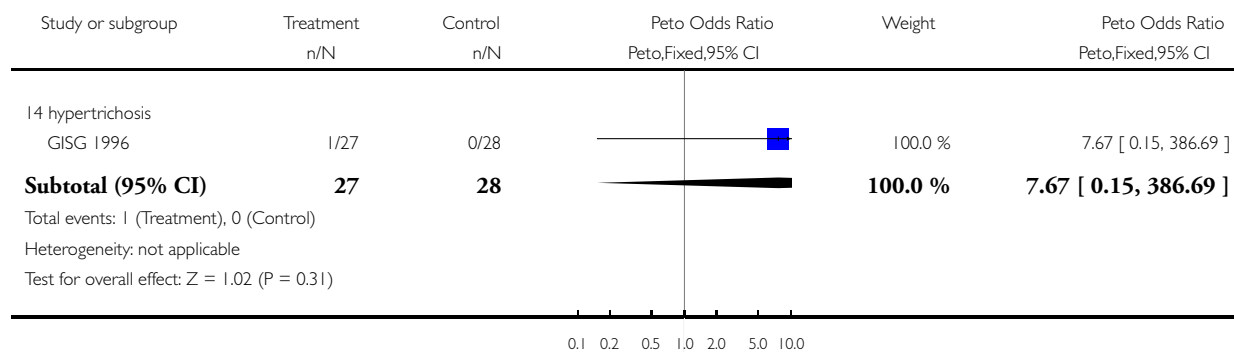
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

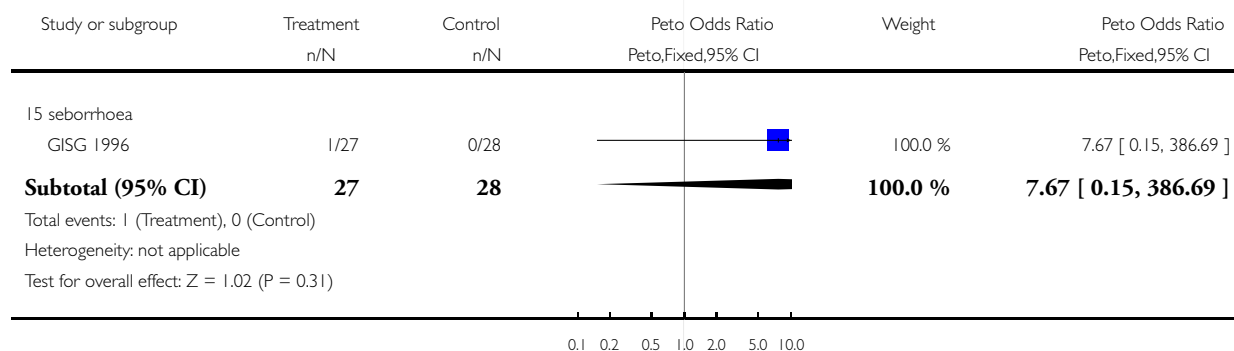
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

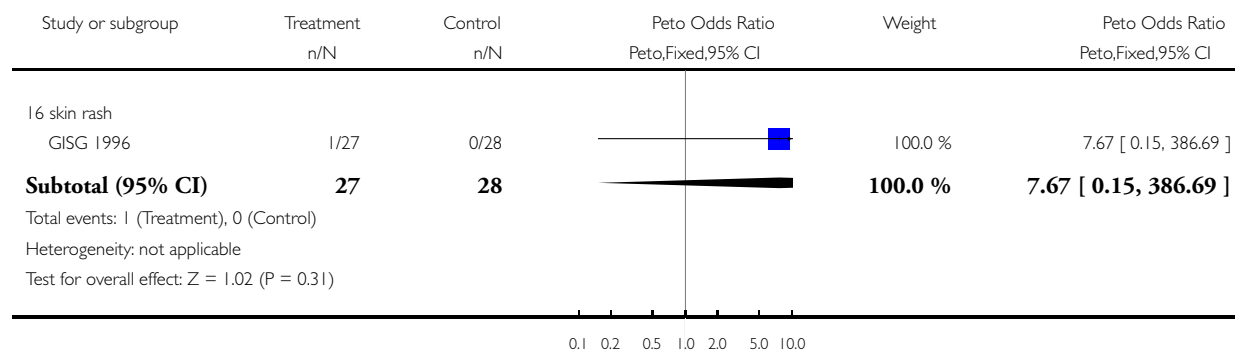
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

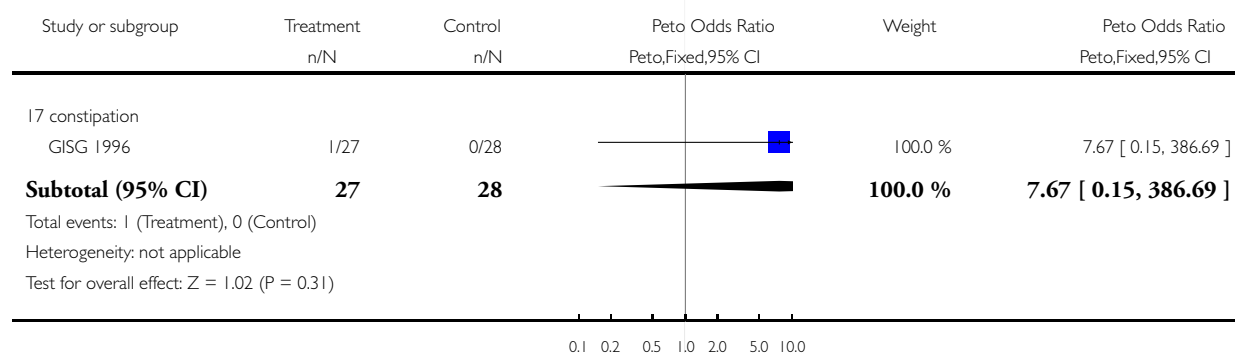
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

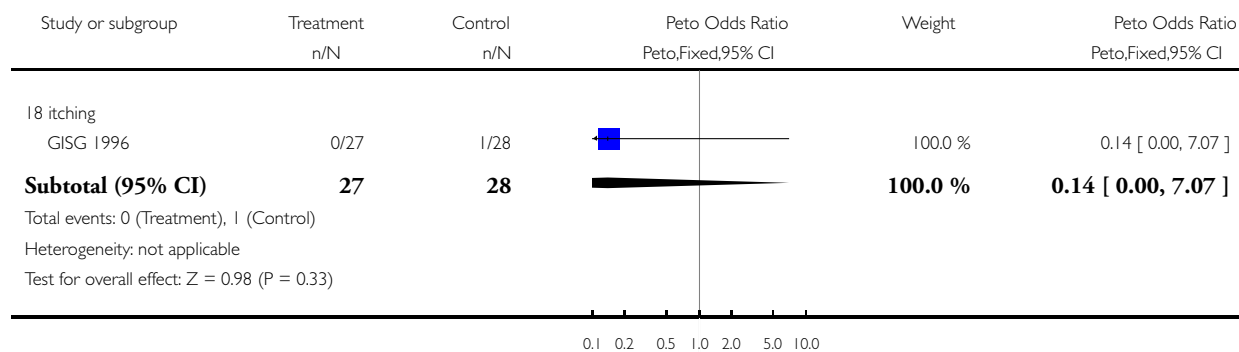
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: I I GESTRINONE VS GnRH ANALOGUE

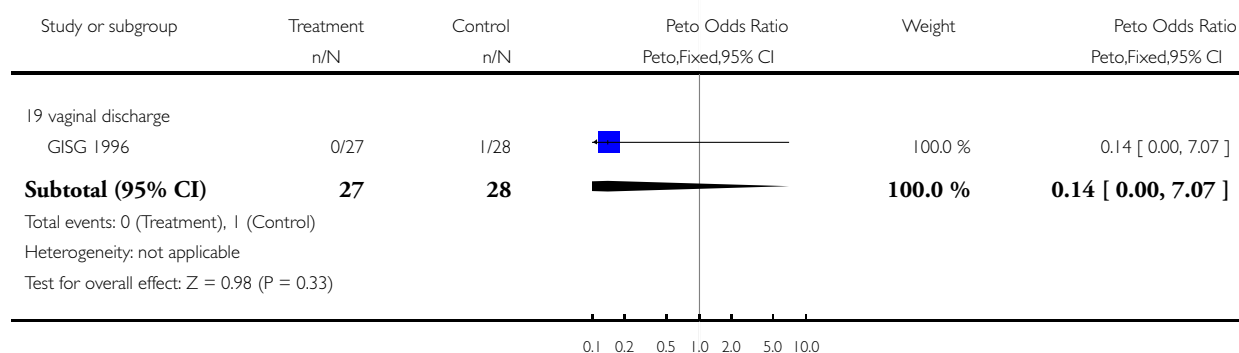
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: I I GESTRINONE VS GnRH ANALOGUE

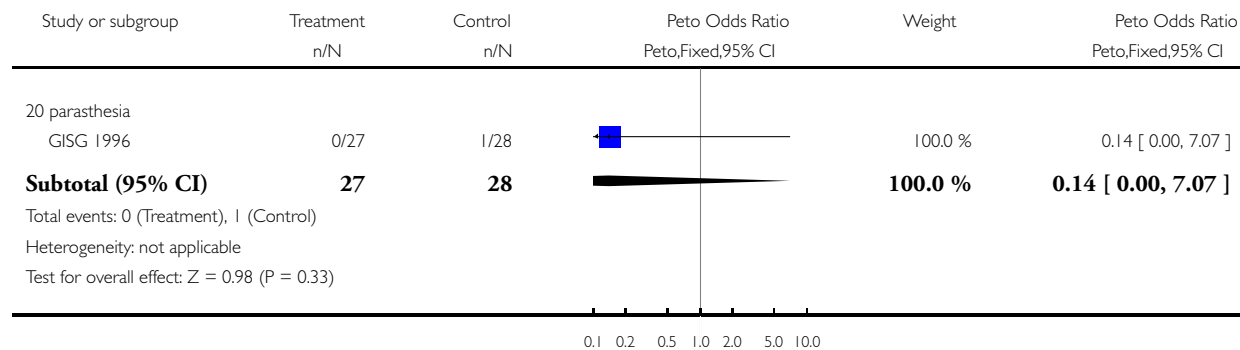
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

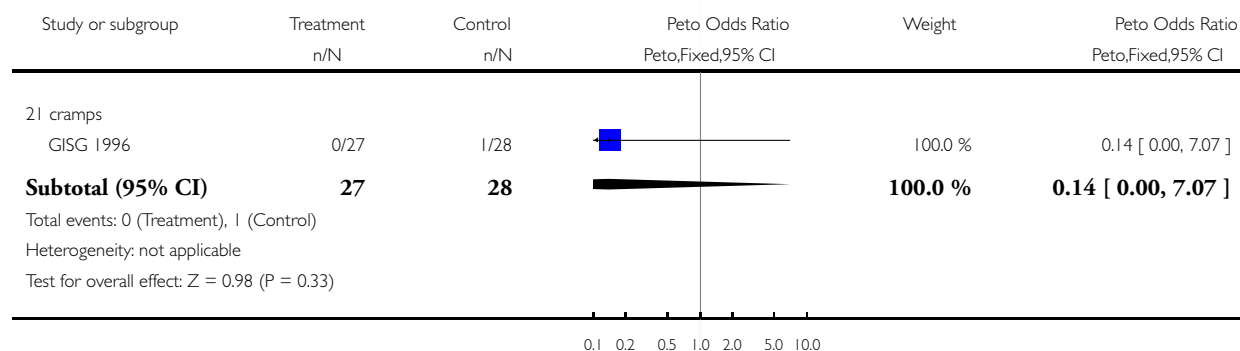
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

Outcome: 3 Side effects

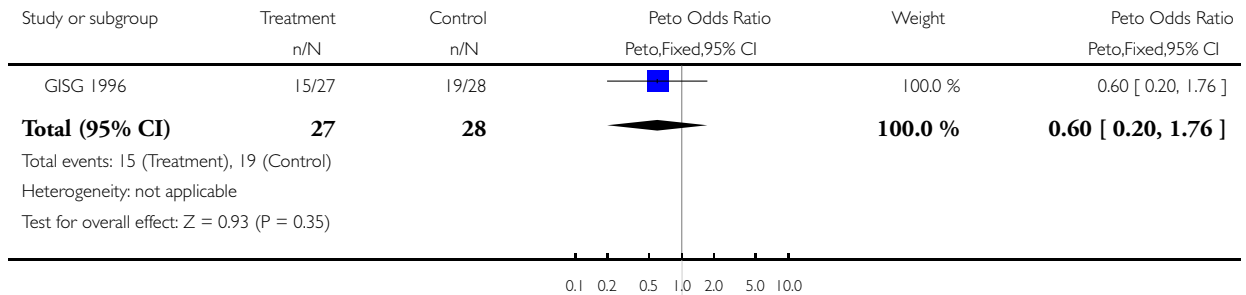


Analysis 11.4. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 4 Suffered any side-effect.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

Outcome: 4 Suffered any side-effect

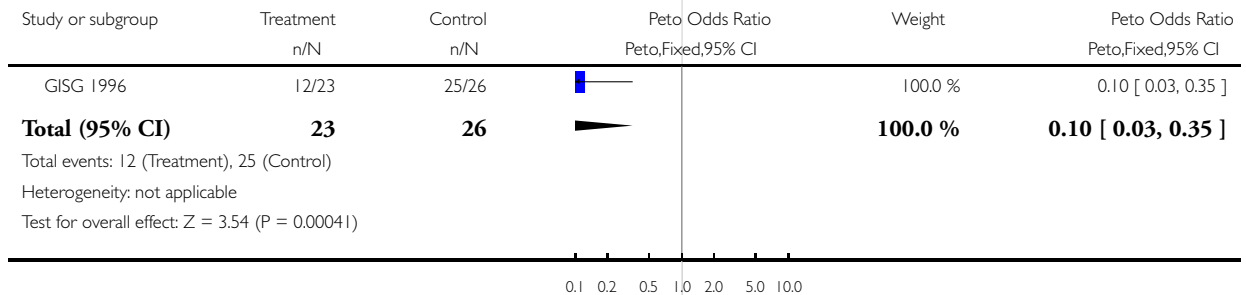


Analysis 11.5. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 5 Amenorrhoeic during treatment.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

Outcome: 5 Amenorrhoeic during treatment

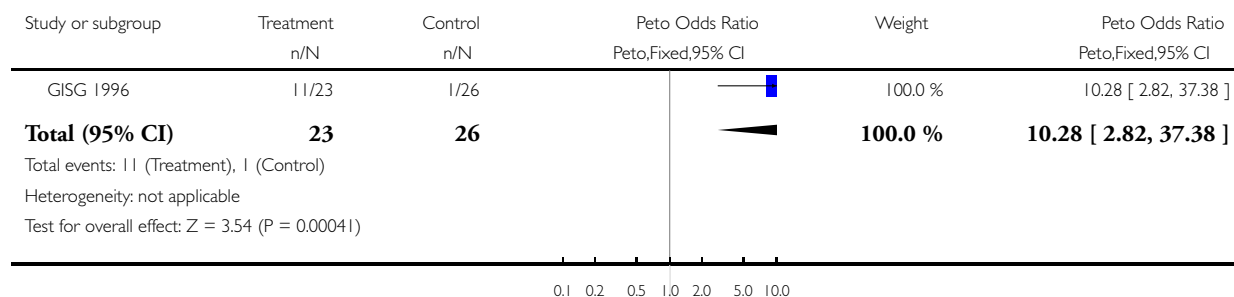


Analysis 11.6. Comparison 11 GESTRINONE VS GnRH ANALOGUE, Outcome 6 Spotting or bleeding during treatment.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 11 GESTRINONE VS GnRH ANALOGUE

Outcome: 6 Spotting or bleeding during treatment

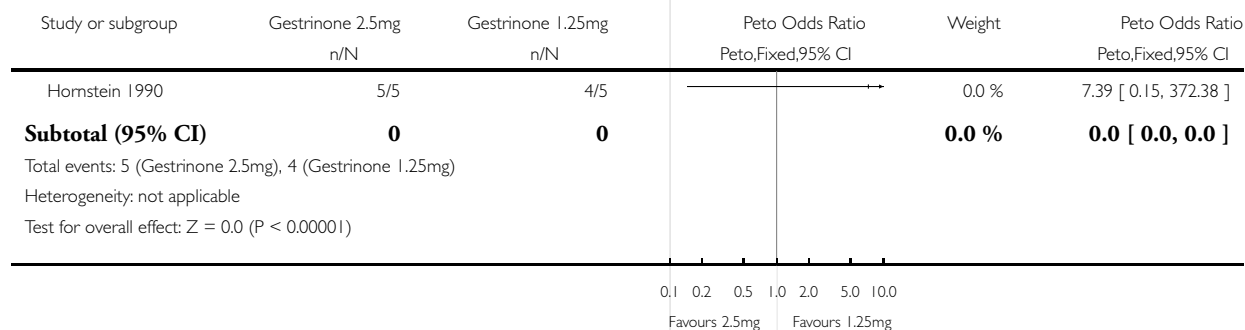


Analysis 12.1. Comparison 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE), Outcome 1 Subjective improvement in pain.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

Outcome: 1 Subjective improvement in pain

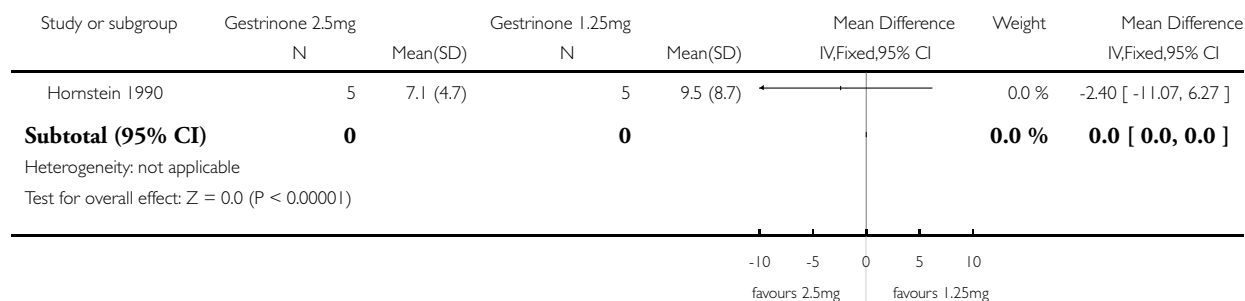


Analysis 12.2. Comparison 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE), Outcome 2 Objective efficacy -rAFS scores at 6 months.

Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

Outcome: 2 Objective efficacy -rAFS scores at 6 months

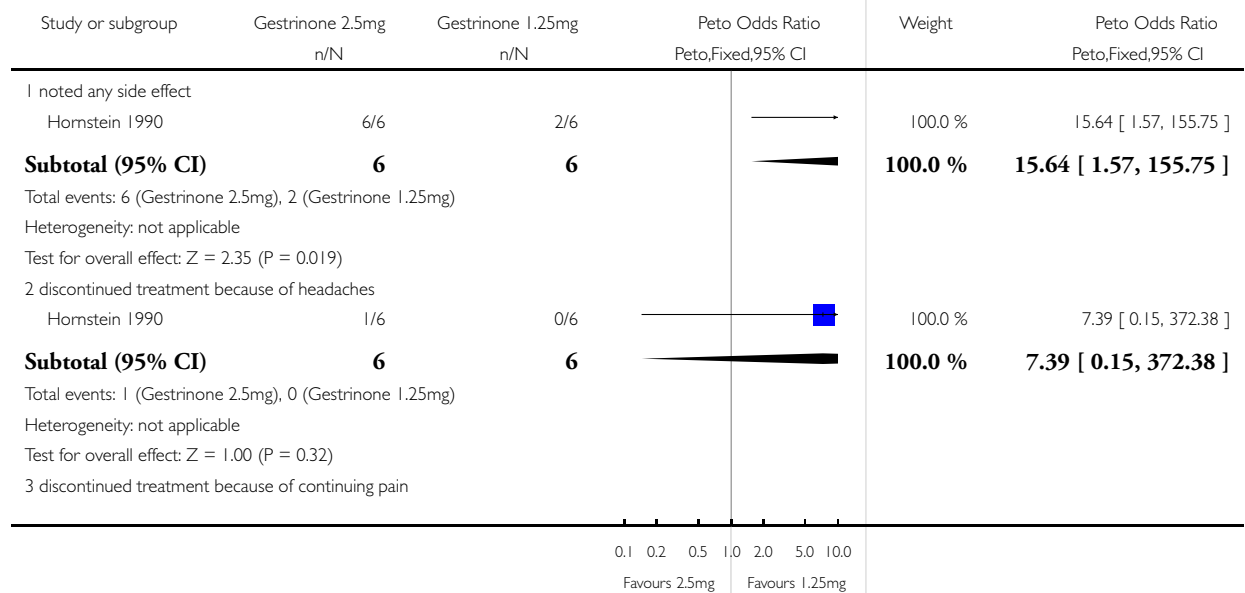


Analysis 12.3. Comparison 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE), Outcome 3 Side effects.

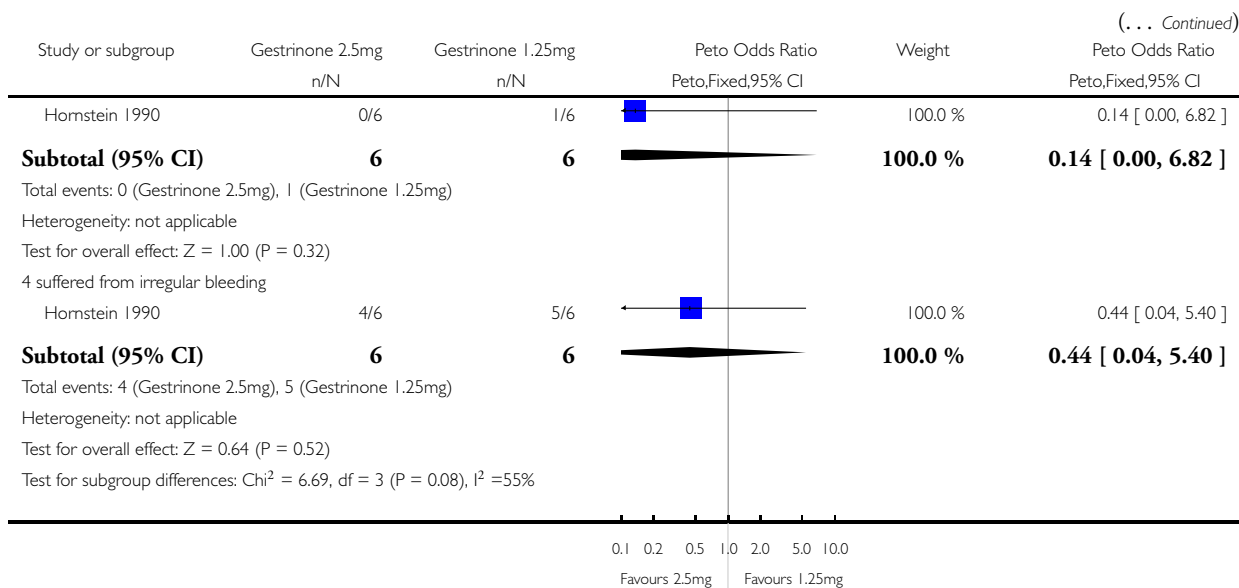
Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

Outcome: 3 Side effects



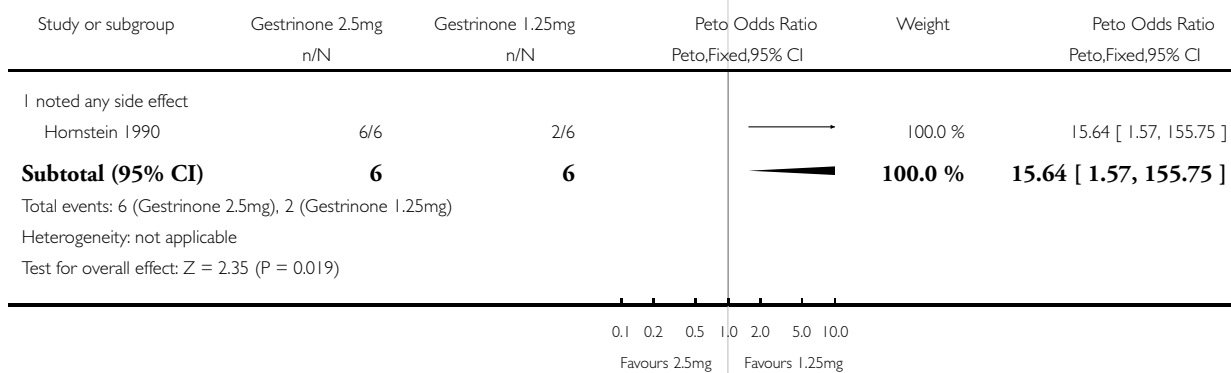
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Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

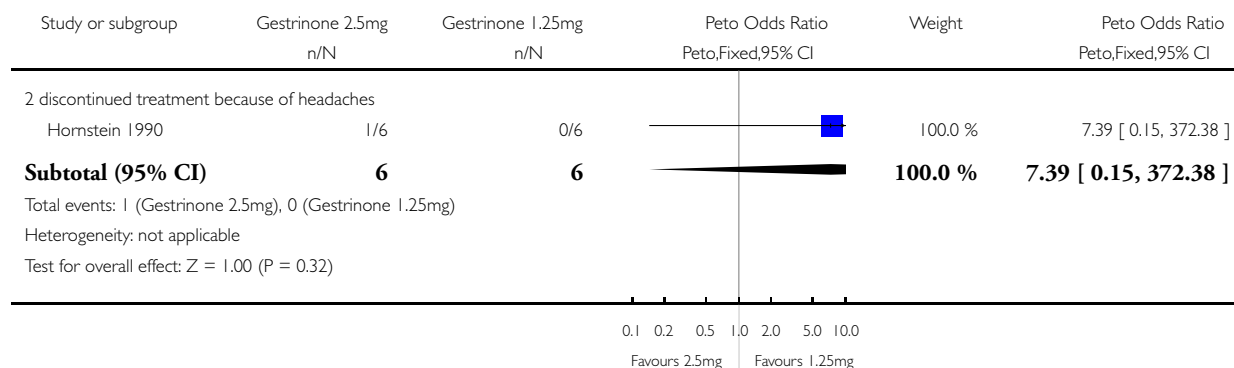
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

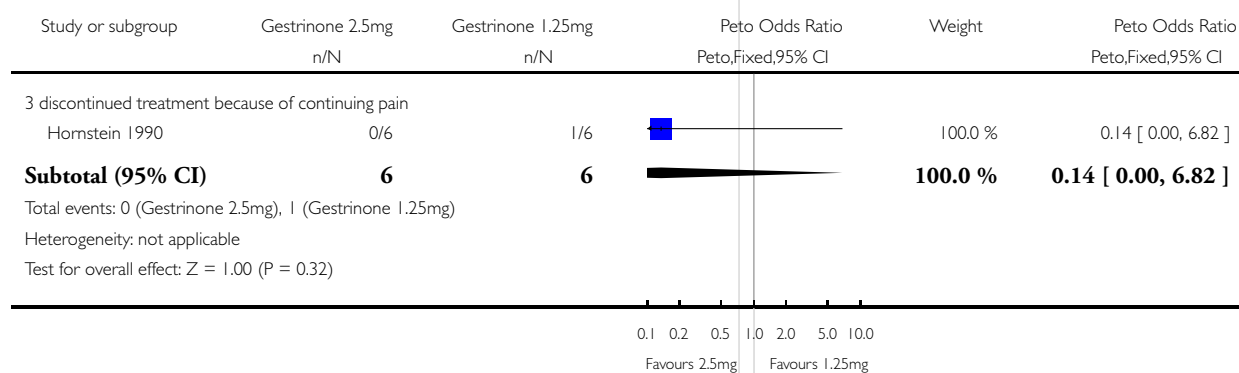
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

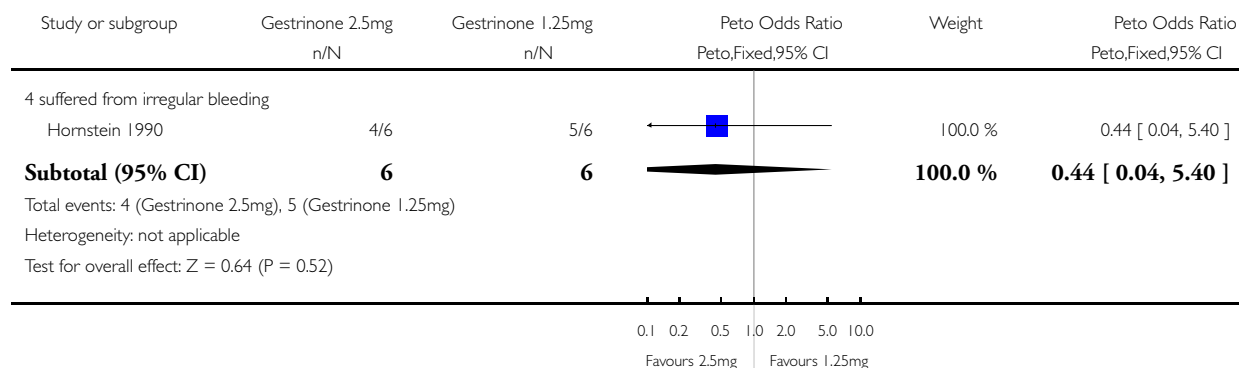
Outcome: 3 Side effects



Review: Progestagens and anti-progestagens for pain associated with endometriosis

Comparison: 12 GESTRINONE VS GESTRINONE (VARYING DOSAGE)

Outcome: 3 Side effects



WHAT'S NEW

Last assessed as up-to-date: 16 January 2000.

6 November 2008	Amended	Converted to new review format.
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HISTORY

Protocol first published: Issue 1, 1997

Review first published: Issue 2, 2000

17 January 2000	New citation required and conclusions have changed	Substantive amendment
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CONTRIBUTIONS OF AUTHORS

Not completed by review authors

DECLARATIONS OF INTEREST

AJD was partly employed on a non-conditional educational grant from Zeneca Pharma. The grant was utilised to provide a telephone support line for endometriosis patients attending a tertiary specialist clinic.

SOURCES OF SUPPORT

Internal sources

- University of Cambridge, UK.

External sources

- The Cambridge University Hospital's NHS Trust, UK.

INDEX TERMS

Medical Subject Headings (MeSH)

Dydrogesterone [therapeutic use]; Endometriosis [complications; *drug therapy]; Gestrinone [therapeutic use]; Medroxyprogesterone 17-Acetate [therapeutic use]; Pain [drug therapy; etiology]; Progesterone Congeners [*therapeutic use]; Progestins [*antagonists & inhibitors]

MeSH check words

Female; Humans